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Ninety Years of Health Insurance Reform Efforts in California

Bill and Proposition Files

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October 2007

AMENDED IN SENATE JUNE 4, 1992

AMENDED IN SENATE APRIL 20, 1992

CALIFORNIA LEGISLATURE—1991–92 REGULAR SESSION

ASSEMBLY BILL No. 502

Introduced by Assembly Member Margolin
(Principal coauthor: Senator Torres)
(Coauthors: Assembly Members Connelly, Eastin, and Isenberg)
(Coauthors: Senators *Cecil Green,* Hart, Johnston, and Watson)

February 13, 1991

An act to add Division 9 (commencing with Section 20000) to the Insurance Code, relating to health coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 502, as amended, Margolin. Health coverage.

Existing law establishes the Tucker Health Care Coverage Act of 1989, that authorizes every employer, as defined, to provide health care coverage with prescribed benefits to each employee, as defined, in a certain manner.

This bill would enact the California Health Reform Act of 1992. The bill would create the California Health Plan Commission, with prescribed membership and powers.

The bill would require the commission to establish and maintain for all California residents a prescribed system of universal health care coverage to be known as the California Health Plan, except that the bill would provide that this provision would not become operative until such time as the Legislature declares it to be operative and appropriates funds necessary to implement the provision.

The bill would require the commission to produce and deliver to the Legislature a prescribed plan for implementation of the California Health Plan, on or before July 1, 1993.

The bill would require the commission, on or before July 1, 1994, to report in a certain manner to the Legislature concerning the means by which needs for long-term care services can be met.

The bill would appropriate $1,000,000 from the General Fund to the commission for the 1992–93 fiscal year to carry out the purposes of the act.

The bill would prohibit anything in the act from being construed to create any entitlement to health care coverage for any person until such time as the Legislature appropriates the funds necessary to implement the program of universal health care coverage described by the act.

Vote: ⅔. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and may be cited as the California Health Reform Act of 1992.

SEC. 2. The Legislature finds and declares all of the following:

(a) All California residents have a right to affordable, medically necessary health care and to nondiscriminatory treatment by health care providers and insurers.

(b) Approximately 6,000,000 people in California, 80 percent of them workers and dependents, are uninsured. Uninsured workers are disproportionately low wage employees working in small businesses, especially in the service industry, agriculture, fishing, and other jobs where health insurance is not provided. The number of uninsured people in the state has grown at an alarming rate as California's business economy has shifted in the direction of small business and the service industry, and as the cost of providing health insurance has escalated.

(c) Millions of California residents have inadequate

insurance which either does not protect against the catastrophic costs of major illness because of inadequate benefits or preexisting condition exclusions, or contains cost-sharing requirements that are unaffordable.

(d) In addition to those who cannot afford health insurance, many California residents are uninsurable because health carriers reject applicants on the basis of medical history and exclude preexisting medical conditions from insurance coverage.

(e) For many uninsured Californians, the lack of health insurance limits access to medical care, especially to cost-effective primary and preventive care, and results in poor health, illness, and death. In addition, many uninsured Californians experience medical crises and require expensive emergency room and tertiary care because they lack primary and preventive care. The resulting demands on emergency and trauma care resources place a significant financial burden on the public and endanger both the county "safety net" system that serves the poor and the trauma care system that serves the whole population.

(f) Per capita health care costs in the United States are escalating at a rate substantially higher than the consumer price index and are the highest in the world, even though the United States differs from all other major industrial countries except South Africa in failing to provide universal coverage. California's health costs are among the highest in the United States.

(g) Administrative waste is one of the major causes of excessive health care costs. Unnecessary administrative costs include the ongoing costs of underwriting individuals and groups and the frequent enrollment in and disenrollment from health plans associated with our current employer-based system of health coverage. Other causes of excessive health costs include the unchecked growth of medical technology and the prevalence of unnecessary care.

(h) The duplicative and overlapping health coverage provided through health insurance, workers' compensation, and automobile insurance is another

significant source of administrative waste in the health care system and results in costly and unnecessary lawsuits.

(i) The current crisis in medical costs has had a substantial and negative impact on California businesses and employees. Businesses that provide health coverage are paying an increasing percentage of their profits for this coverage. They are absorbing cost shifts attributable to care provided to the uninsured, including low wage employees of businesses that do not provide coverage. As a result of the explosion in medical costs, employee benefits have eroded and health benefits have become a primary focus of labor disputes. Small businesses are at a particular disadvantage affording, qualifying for, and keeping health insurance, and California companies doing business internationally are at a competitive disadvantage with businesses located in other countries that provide universal health care.

(j) The current employment-linked system of health coverage is regressively financed, has resulted in inequitable distribution of benefits and instability of coverage, and has contributed to the phenomenon of "job lock," in which workers with chronic medical conditions or ill dependents cannot change jobs for fear of losing their medical insurance.

(k) California is facing dramatic increases in the demand for long-term care as a result of the aging of the population, medical technology, increasing numbers of children born with disabilities, and growing numbers of people with AIDS, Alzheimer's disease, and other debilitating conditions. Most Californians do not have a realistic means of financing long-term care without impoverishment.

(*l*) Large numbers of Californians are ~~satisfied~~ *dissatisfied* with the way in which they currently receive health care.

(m) Any successful plan to address the problems in our health system will have to address both access and cost. This can best be done through a single, unified system of health coverage.

(n) Redesigning the health system is a major effort that must start with public education and discussion, and with responsible planning.

SEC. 3. It is the intent of the Legislature to do all of the following:

(a) Implement, on or before January 1, 1995, a universal health program under which all California residents are eligible for coverage through private health plans that provide comprehensive, medically necessary health care, including primary and preventive care, and that compete on the basis of quality and price rather than through avoidance of risk.

(b) Establish a commission to begin implementation of the universal health program and to report back to the Legislature concerning the next legislative steps that must be taken to implement the program fully.

(c) Eliminate the link between employment and eligibility for health coverage.

(d) Fund the universal health program in a manner which is fair and stable and which fairly spreads the financial burden among Californians on the basis of ability to pay.

(e) Contain health care costs by controlling administrative waste; reducing legal costs by providing health coverage through one system regardless of the cause of injury or illness; encouraging competition among carriers over price and service rather than risk avoidance; and addressing the causes of escalating costs, such as unrestricted growth of technology.

(f) Determine whether it is feasible, at the state level, to provide long-term care coverage to Californians in a way that is cost-effective and fair, and that integrates long-term care services with general health care.

SEC. 4. Division 9 (commencing with Section 20000) is added to the Insurance Code, to read:

DIVISION 9. CALIFORNIA HEALTH PLAN

CHAPTER 1. DEFINITIONS

20000. The definitions contained in this chapter shall govern the construction of this division, unless the context requires otherwise.

20002. "Commission" means the California Health Plan Commission.

20004. "Private health plan" means any privately administered health *care* service plan, policy of disability insurance, nonprofit hospital service plan, or any other mode of delivery of health care that is certified pursuant to paragraph (1) of subdivision (c) of Section 20030 and that provides health care services to individuals in exchange for a prescribed premium or charge paid pursuant to the program of universal health coverage established by this division.

20006. "Federal poverty income level" means the federal official poverty line, as defined by the Federal Office of Management and Budget, based on Bureau of Census data, and revised annually by the Secretary of Health and Human Services pursuant to Section 9902(2) of Title 42 of the United States Code.

CHAPTER 2. CALIFORNIA HEALTH PLAN COMMISSION

20020. There is in the state government the California Health Plan Commission, that shall be an independent authority.

20021. (a) The commission shall consist of seven members, who shall be appointed as follows:

(1) Three persons, one of whom shall represent businesses with 50 or more employees and one of whom shall represent businesses with fewer than 50 employees, to be appointed by the Governor.

(2) One person, who shall represent public sector employees, to be appointed by the Speaker of the Assembly.

(3) One person, who has experience representing consumers with special needs, such as low-income persons, persons whose primary language is not English, disabled and chronically ill persons, and elderly persons, and who shall have no business or employment interest

in the health care sector, to be appointed by the Senate Committee on Rules.

(4) Two persons, one of whom shall represent consumers and who shall have no business or employment interest in the health care sector, and one of whom shall represent private sector employees, to be appointed by the Insurance Commissioner.

(b) In making appointments to the commission, all appointing sources shall consider the value of a commission that reflects the ethnic and social diversity of the population to be served by the program of universal health coverage to be developed by the commission.

(c) Members of the commission shall serve for staggered six-year terms.

(d) Initial appointments to the commission shall be made by all appointing powers no later than January 1, 1993, and initial appointees shall serve as follows:

(1) Two of the initial appointees shall serve two-year terms.

(2) Two of the initial appointees shall serve four-year terms.

(3) Three of the initial appointees shall serve six-year terms.

(4) The term of each initial appointee shall be determined by lot following the initial appointment of all members.

(e) A member whose term has expired shall continue to serve until his or her successor is appointed and qualified. Appointments to fill vacancies shall be made by the original appointing authorities.

(f) Notwithstanding any other provision of this section, the powers and duties of the commission shall terminate on January 1, 1995, unless the Legislature takes action to continue the commission in existence.

20022. Members of the commission shall receive actual necessary traveling expenses and a per diem allowance of one hundred dollars ($100) for each day spent in meetings of the commission or on commission business.

20023. The commission may enter into contracts and

hire staff to carry out the purposes of this division and the commission shall reimburse from its appropriation all public or private agencies or persons for any and all services provided by these agencies or persons as necessary to carry out the purposes of this division.

20024. To assist it in fulfilling the purposes of this division, the commission shall establish one or more advisory panels, which shall include experts concerning provision of health care, including at least one physician and surgeon, one nurse, one hospital administrator, and one representative of a community health center, experts concerning the operation of the existing county "safety net," and experts concerning the needs of low-income persons, persons who do not speak English as their primary language, persons with mental or physical disabilities, persons with chronic medical conditions, and elderly persons.

CHAPTER 3. CALIFORNIA HEALTH PLAN

20030. The commission shall establish and maintain, for all California residents, a system of universal health coverage to be known as the California Health Plan, under which all of the following shall be provided:

(a) All California residents shall be eligible for the same, state-guaranteed package of comprehensive, medically necessary health care services, including primary and preventive care, provided through competing private health plans, that must accept all eligible individuals regardless of health status and without individual medical underwriting, preexisting condition exclusions, or waiting periods.

(b) Health care shall be provided to all California residents through a single, cost-effective system of coverage regardless of the cause of injury or illness, and under which the health care coverage currently provided through workers' compensation and automobile insurance shall be provided instead through the universal health care system, with at least 50 percent of any savings resulting from the consolidation of the workers'

compensation and health care systems to be used to increase workers' compensation benefits.

(c) Regional health insurance purchasing corporations established and funded by the commission and composed primarily of consumers and employers shall do all of the following:

(1) Certify private health plans for participation in the system of universal health coverage on the basis of ability to deliver the state-guaranteed package of comprehensive, medically necessary health services in accordance with defined criteria for quality and service.

(2) Pay each certified private health plan the same, risk-adjusted per capita amount for all participating individuals.

(3) Enforce standards limiting the additional premiums that private health plans may charge subscribers.

(4) Ensure that no participating private health plan that charges any additional premium to subscribers shall charge an eligible person a higher premium than that charged to any other eligible person.

(5) In all regions, ensure that all consumers have the option of at least one health plan which will provide the state-guaranteed package of comprehensive, medically necessary health services for no additional premium above that paid on their behalf by the Regional Health Insurance Purchasing Corporation.

(6) Except in underserved areas in which the purchasing corporation determines that there are insufficient providers to support more than one private health plan, ensure that all consumers have a choice of at least two private health plans that will provide the state-guaranteed package of comprehensive, medically necessary health services for no additional premium above that paid on their behalf by the regional health insurance purchasing corporation.

(7) Make provision to assist all California residents in choosing among certified private health plans by providing consumer education, including uniform information about all the certified private health plans in

a given region.

(8) Provide a mechanism for enrolling all eligible persons in their chosen private health plans.

(9) Monitor and enforce standards concerning access and quality of care in all private health plans.

(10) In conjunction with the commission, collect data from all certified private health plans and sponsor research into health outcomes and practice guidelines in order to facilitate fair competition and cost containment.

(11) Where necessary to meet the needs of underserved areas or special populations, organize the delivery of health care.

(12) In conjunction with the commission, ensure funding and operation of a public "safety net" health care system to the extent necessary to meet the needs of any persons not served by certified private health plans.

(13) In conjunction with the commission, ensure funding and operation of a trauma care system adequate to serve the emergency medical needs of all persons in California.

(d) All California residents shall be eligible to participate without regard to employment status or place of employment.

(e) California's health costs shall be contained through reduction of administrative costs, competition regarding price and service rather than risk avoidance, adoption of an overall health care budget, collection and dissemination of data aimed at reducing the incidence of inappropriate care, establishment of fair and compassionate public processes for addressing both the dissemination of new technology and the limitation of clinically ineffective care, and maximization of federal dollars through the Medi-Cal program.

(f) Financing shall be through assessments, including payroll-based contributions paid by employers, employees, and self-employed persons, that shall be fair and stable, that spread the financial burden among Californians on the basis of ability to pay, that take into account the particular financial constraints on lower income workers and on new or small businesses, and that

are, on average, as a percentage of payroll, for employers who provided health coverage, lower than the average per capita premiums paid by the employers immediately prior to the implementation of the California Health Plan.

(g) Persons with income at or below 200 percent of the federal poverty income guidelines shall be exempt from from cost-sharing requirements, and other persons may be required to pay limited copayments but no deductibles, provided that cost sharing within plans shall not be a barrier to utilization of necessary service by persons at any income level.

(h) This section shall not become operative until such time as the Legislature declares this section to be operative and appropriates the funds necessary to implement this section.

20032. As the first step in the implementation of the program of universal health care established by this chapter, the commission shall, on or before January 1, 1994, produce and deliver to the Legislature a detailed plan for implementation of the program. The plan shall contain detailed recommendations for the program's financing, including an analysis of costs and financing options, and detailed statements concerning the program's administration, including, but not limited to, all of the following:

(a) The responsibilities of the commission and of the regional health insurance purchasing corporations.

(b) The steps necessary to include the populations served by the Medi-Cal and Medicare programs in the California Health Plan, including a statement of any necessary federal waivers and a statement of any unique needs of the Medi-Cal and Medicare populations.

(c) The role of other existing publicly financed systems of health coverage, including the Public Employees' Retirement System, federal employee health benefits, health benefits for armed services members, the Veterans Administration, the ~~CHAMPUS program~~ *Civilian Health and Medical Program of the Uniformed Services* (10 U.S.C. Sec. 1071 et seq.), and any other

mandated by state or federal law.

(d) The role of existing retirement health benefits.

(e) Standards for eligibility and how eligibility standards shall be administered.

(f) The benefits which should be included in the state-guaranteed set of comprehensive, medically necessary health care services.

(g) The number of regions and regional health insurance purchasing corporations that shall be established.

(h) The composition of the regional health insurance purchasing corporations.

(i) The mechanisms for ensuring that the private health plans available to all California residents for no additional premium beyond that paid by the regional health insurance purchasing corporations will provide appropriate access to quality medical services, including a requirement that those private health plans that are permitted to charge an additional premium to consumers accept a specified percentage of low-income people for no additional premium or, alternatively, a surcharge on premiums paid to those private health plans that are permitted to charge an additional premium to consumers.

(j) The means by which the program will ensure that the needs of special populations such as low-income persons, people living in rural and underserved areas, people speaking a primary language other than English, and people with disabilities and chronic or unusual medical needs will be met.

(k) The remaining need for a safety net health care system for persons not served by certified private health plans, including the role of the existing county health care system and of the current obligations defined by Section 17000 of the Welfare and Institutions Code, once the universal health program is fully implemented.

(*l*) The mechanisms for consolidating the health care components of workers' compensation and automobile insurance with the health coverage provided under the universal health program, considering the effect of any

proposal on workers' current entitlements.

(m) The role of teaching hospitals, medical education, and medical research in the California Health Plan, and the appropriate means of financing these functions.

(n) The appropriate roles of the regional health insurance purchasing corporations and the statewide commission in collecting data for both quality assurance and cost containment, in developing or disseminating medical practice parameters, and in guiding the proliferation of new medical technologies.

(o) Options for phasing in the universal health program described in this division.

20034. On or before July 1, 1994, the commission shall study, and report to the Legislature concerning, the means by which Californians' need for long-term care services can best be met. The commission shall make recommendations concerning the role of long-term care services in the California Health Plan, including the feasibility of including universal, comprehensive access to home, community-based, and institutional services, the feasibility of taking incremental steps toward provision of comprehensive long-term care, the recommended means for financing long-term care, and the appropriate role of the federal and state governments and of private insurance in addressing Californians' long-term care needs.

SEC. 5. There is hereby appropriated from the ~~General~~ *Insurance* Fund to the California Health Plan Commission the sum of ~~one million dollars ($1,000,000)~~ *two hundred fifty thousand dollars ($250,000)* for the 1992–93 fiscal year, to carry out the purposes of Division 9 (commencing with Section 20000) of the Insurance Code. *In addition to the appropriation made by this section, the California Health Plan Commission may receive funds in the form of grants and gifts from private, nonprofit, or other public agencies.*

SEC. 6. Nothing in this act shall be construed to create any entitlement to health care coverage for any person until such time as the Legislature shall appropriate, pursuant to all applicable law, the funds

AMENDED IN ASSEMBLY JUNE 27, 1992

AMENDED IN ASSEMBLY APRIL 20, 1992

AMENDED IN ASSEMBLY JUNE 18, 1991

AMENDED IN SENATE JUNE 6, 1991

AMENDED IN SENATE MAY 22, 1991

AMENDED IN SENATE MAY 9, 1991

SENATE BILL No. 6

Introduced by Senator Torres
(Principal coauthor: Assembly Member Margolin)
(Coauthors: Senators *Cecil Green*, Hart, Johnston, and Watson)
(Coauthors: Assembly Members Connelly, Eastin, and Isenberg)

December 3, 1990

An act to add Division 9 (commencing with Section 20000) to the Insurance Code, relating to insurance, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 6, as amended, Torres. Health insurance.

Existing law establishes the Tucker Health Care Coverage Act of 1989, that authorizes every employer, as defined, to provide health care coverage with prescribed benefits to each employee, as defined, in a certain manner.

This bill would enact the California Health Reform Act of 1992. The bill would create the California Health Plan Commission, with prescribed membership and powers.

The bill would require the commission to establish and maintain for all California residents a prescribed system of universal health care coverage to be known as the California

Health Plan, except that the bill would provide that this provision would not become operative until such time as the Legislature declares it to be operative and appropriates funds necessary to implement the provision.

The bill would require the commission to produce and deliver to the Legislature a prescribed plan for implementation of the California Health Plan, on or before July 1, 1993.

The bill would require the commission, on or before July 1, 1994, to report in a certain manner to the Legislature concerning the means by which needs for long-term care services can be met.

The bill would appropriate ~~$1,000,000~~ *$250,000* from the ~~General~~ *Insurance* Fund to the commission for the 1992–93 fiscal year to carry out the purposes of the act.

The bill would prohibit anything in the act from being construed to create any entitlement to health care coverage for any person until such time as the Legislature appropriates the funds necessary to implement the program of universal health care coverage described by the act.

Vote: ~~2/3~~ *majority*. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and may be cited as the California Health Reform Act of 1992.

SEC. 2. The Legislature finds and declares all of the following:

(a) All California residents have a right to affordable, medically necessary health care and to nondiscriminatory treatment by health care providers and insurers.

(b) Approximately 6,000,000 people in California, 80 percent of them workers and dependents, are uninsured. Uninsured workers are disproportionately low wage employees working in small businesses, especially in the service industry, agriculture, fishing, and other jobs where health insurance is not provided. The number of uninsured people in the state has grown at an alarming

rate as California's business economy has shifted in the direction of small business and the service industry, and as the cost of providing health insurance has escalated.

(c) Millions of California residents have inadequate insurance which either does not protect against the catastrophic costs of major illness because of inadequate benefits or preexisting condition exclusions, or contains cost-sharing requirements that are unaffordable.

(d) In addition to those who cannot afford health insurance, many California residents are uninsurable because health carriers reject applicants on the basis of medical history and exclude preexisting medical conditions from insurance coverage.

(e) For many uninsured Californians, the lack of health insurance limits access to medical care, especially to cost-effective primary and preventive care, and results in poor health, illness, and death. In addition, many uninsured Californians experience medical crises and require expensive emergency room and tertiary care because they lack primary and preventive care. The resulting demands on emergency and trauma care resources place a significant financial burden on the public and endanger both the county "safety net" system that serves the poor and the trauma care system that serves the whole population.

(f) Per capita health care costs in the United States are escalating at a rate substantially higher than the consumer price index and are the highest in the world, even though the United States differs from all other major industrial countries except South Africa in failing to provide universal coverage. California's health costs are among the highest in the United States.

(g) Administrative waste is one of the major causes of excessive health care costs. Unnecessary administrative costs include the ongoing costs of underwriting individuals and groups and the frequent enrollment in and disenrollment from health plans associated with our current employer-based system of health coverage. Other causes of excessive health costs include the unchecked growth of medical technology and the

prevalence of unnecessary care.

(h) The duplicative and overlapping health coverage provided through health insurance, workers' compensation, and automobile insurance is another significant source of administrative waste in the health care system and results in costly and unnecessary lawsuits.

(i) The current crisis in medical costs has had a substantial and negative impact on California businesses and employees. Businesses that provide health coverage are paying an increasing percentage of their profits for this coverage. They are absorbing cost shifts attributable to care provided to the uninsured, including low wage employees of businesses that do not provide coverage. As a result of the explosion in medical costs, employee benefits have eroded and health benefits have become a primary focus of labor disputes. Small businesses are at a particular disadvantage affording, qualifying for, and keeping health insurance, and California companies doing business internationally are at a competitive disadvantage with businesses located in other countries that provide universal health care.

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our health system will have to address both access and cost. This can best be done through a single, unified system of health coverage.

(n) Redesigning the health system is a major effort that must start with public education and discussion, and with responsible planning.

SEC. 3. It is the intent of the Legislature to do all of the following:

(a) Implement, on or before January 1, 1995, a universal health program under which all California residents are eligible for coverage through private health plans that provide comprehensive, medically necessary health care, including primary and preventive care, and that compete on the basis of quality and price rather than through avoidance of risk.

(b) Establish a commission to begin implementation of the universal health program and to report back to the Legislature concerning the next legislative steps that must be taken to implement the program fully.

(c) Eliminate the link between employment and eligibility for health coverage.

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(e) Contain health care costs by controlling administrative waste; reducing legal costs by providing health coverage through one system regardless of the cause of injury or illness; encouraging competition among carriers over price and service rather than risk avoidance; and addressing the causes of escalating costs, such as unrestricted growth of technology.

(f) Determine whether it is feasible, at the state level, to provide long-term care coverage to Californians in a way that is cost-effective and fair, and that integrates long-term care services with general health care.

SEC. 4. Division 9 (commencing with Section 20000) is added to the Insurance Code, to read:

DIVISION 9. CALIFORNIA HEALTH PLAN

CHAPTER 1. DEFINITIONS

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CHAPTER 2. CALIFORNIA HEALTH PLAN COMMISSION

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20021. (a) The commission shall consist of seven members, who shall be appointed as follows:

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(2) One person, who shall represent public sector employees, to be appointed by the Speaker of the Assembly.

(3) One person, who has experience representing

consumers with special needs, such as low-income persons, persons whose primary language is not English, disabled and chronically ill persons, and elderly persons, and who shall have no business or employment interest in the health care sector, to be appointed by the Senate Committee on Rules.

(4) Two persons, one of whom shall represent consumers and who shall have no business or employment interest in the health care sector, and one of whom shall represent private sector employees, to be appointed by the Insurance Commissioner.

(b) In making appointments to the commission, all appointing sources shall consider the value of a commission that reflects the ethnic and social diversity of the population to be served by the program of universal health coverage to be developed by the commission.

(c) Members of the commission shall serve for staggered six-year terms.

(d) Initial appointments to the commission shall be made by all appointing powers no later than January 1, 1993, and initial appointees shall serve as follows:

(1) Two of the initial appointees shall serve two-year terms.

(2) Two of the initial appointees shall serve four-year terms.

(3) Three of the initial appointees shall serve six-year terms.

(4) The term of each initial appointee shall be determined by lot following the initial appointment of all members.

(e) A member whose term has expired shall continue to serve until his or her successor is appointed and qualified. Appointments to fill vacancies shall be made by the original appointing authorities.

(f) Notwithstanding any other provision of this section, the powers and duties of the commission shall terminate on January 1, 1995, unless the Legislature takes action to continue the commission in existence.

20022. Members of the commission shall receive actual necessary traveling expenses and a per diem

allowance of one hundred dollars ($100) for each day spent in meetings of the commission or on commission business.

20023. The commission may enter into contracts and hire staff to carry out the purposes of this division and the commission shall reimburse from its appropriation all public or private agencies or persons for any and all services provided by these agencies or persons as necessary to carry out the purposes of this division.

20024. To assist it in fulfilling the purposes of this division, the commission shall establish one or more advisory panels, which shall include experts concerning provision of health care, including at least one physician and surgeon, one nurse, one hospital administrator, and one representative of a community health center, experts concerning the operation of the existing county "safety net," and experts concerning the needs of low-income persons, persons who do not speak English as their primary language, persons with mental or physical disabilities, persons with chronic medical conditions, and elderly persons.

CHAPTER 3. CALIFORNIA HEALTH PLAN

20030. The commission shall establish and maintain, for all California residents, a system of universal health coverage to be known as the California Health Plan, under which all of the following shall be provided:

(a) All California residents shall be eligible for the same, state-guaranteed package of comprehensive, medically necessary health care services, including primary and preventive care, provided through competing private health plans, that must accept all eligible individuals regardless of health status and without individual medical underwriting, preexisting condition exclusions, or waiting periods.

(b) Health care shall be provided to all California residents through a single, cost-effective system of coverage regardless of the cause of injury or illness, and under which the health care coverage currently provided

through workers' compensation and automobile insurance shall be provided instead through the universal health care system, with at least 50 percent of any savings resulting from the consolidation of the workers' compensation and health care systems to be used to increase workers' compensation benefits.

(c) Regional health insurance purchasing corporations established and funded by the commission and composed primarily of consumers and employers shall do all of the following:

(1) Certify private health plans for participation in the system of universal health coverage on the basis of ability to deliver the state-guaranteed package of comprehensive, medically necessary health services in accordance with defined criteria for quality and service.

(2) Pay each certified private health plan the same, risk-adjusted per capita amount for all participating individuals.

(3) Enforce standards limiting the additional premiums that private health plans may charge subscribers.

(4) Ensure that no participating private health plan that charges any additional premium to subscribers shall charge an eligible person a higher premium than that charged to any other eligible person.

(5) In all regions, ensure that all consumers have the option of at least one health plan which will provide the state-guaranteed package of comprehensive, medically necessary health services for no additional premium above that paid on their behalf by the Regional Health Insurance Purchasing Corporation.

(6) Except in underserved areas in which the purchasing corporation determines that there are insufficient providers to support more than one private health plan, ensure that all consumers have a choice of at least two private health plans that will provide the state-guaranteed package of comprehensive, medically necessary health services for no additional premium above that paid on their behalf by the regional health insurance purchasing corporation.

(7) Make provision to assist all California residents in choosing among certified private health plans by providing consumer education, including uniform information about all the certified private health plans in a given region.

(8) Provide a mechanism for enrolling all eligible persons in their chosen private health plans.

(9) Monitor and enforce standards concerning access and quality of care in all private health plans.

(10) In conjunction with the commission, collect data from all certified private health plans and sponsor research into health outcomes and practice guidelines in order to facilitate fair competition and cost containment.

(11) Where necessary to meet the needs of underserved areas or special populations, organize the delivery of health care.

(12) In conjunction with the commission, ensure funding and operation of a public "safety net" health care system to the extent necessary to meet the needs of any persons not served by certified private health plans.

(13) In conjunction with the commission, ensure funding and operation of a trauma care system adequate to serve the emergency medical needs of all persons in California.

(d) All California residents shall be eligible to participate without regard to employment status or place of employment.

(e) California's health costs shall be contained through reduction of administrative costs, competition regarding price and service rather than risk avoidance, adoption of an overall health care budget, collection and dissemination of data aimed at reducing the incidence of inappropriate care, establishment of fair and compassionate public processes for addressing both the dissemination of new technology and the limitation of clinically ineffective care, and maximization of federal dollars through the Medi-Cal program.

(f) Financing shall be through assessments, including payroll-based contributions paid by employers, employees, and self-employed persons, that shall be fair

and stable, that spread the financial burden among Californians on the basis of ability to pay, that take into account the particular financial constraints on lower income workers and on new or small businesses, and that are, on average, as a percentage of payroll, for employers who provided health coverage, lower than the average per capita premiums paid by the employers immediately prior to the implementation of the California Health Plan.

(g) Persons with income at or below 200 percent of the federal poverty income guidelines shall be exempt from from cost-sharing requirements, and other persons may be required to pay limited copayments but no deductibles, provided that cost sharing within plans shall not be a barrier to utilization of necessary service by persons at any income level.

(h) This section shall not become operative until such time as the Legislature declares this section to be operative and appropriates the funds necessary to implement this section.

20032. As the first step in the implementation of the program of universal health care established by this chapter, the commission shall, on or before January 1, 1994, produce and deliver to the Legislature a detailed plan for implementation of the program. The plan shall contain detailed recommendations for the program's financing, including an analysis of costs and financing options, and detailed statements concerning the program's administration, including, but not limited to, all of the following:

(a) The responsibilities of the commission and of the regional health insurance purchasing corporations.

(b) The steps necessary to include the populations served by the Medi-Cal and Medicare programs in the California Health Plan, including a statement of any necessary federal waivers and a statement of any unique needs of the Medi-Cal and Medicare populations.

(c) The role of other existing publicly financed systems of health coverage, including the Public Employees' Retirement System, federal employee health

benefits, health benefits for armed services members, the Veterans Administration, the CHAMPUS program (10 U.S.C. Sec. 1071 et seq.), and any other health benefits currently mandated by state or federal law.

(d) The role of existing retirement health benefits.

(e) Standards for eligibility and how eligibility standards shall be administered.

(f) The benefits which should be included in the state-guaranteed set of comprehensive, medically necessary health care services.

(g) The number of regions and regional health insurance purchasing corporations that shall be established.

(h) The composition of the regional health insurance purchasing corporations.

(i) The mechanisms for ensuring that the private health plans available to all California residents for no additional premium beyond that paid by the regional health insurance purchasing corporations will provide appropriate access to quality medical services, including a requirement that those private health plans that are permitted to charge an additional premium to consumers accept a specified percentage of low-income people for no additional premium or, alternatively, a surcharge on premiums paid to those private health plans that are permitted to charge an additional premium to consumers.

(j) The means by which the program will ensure that the needs of special populations such as low-income persons, people living in rural and underserved areas, people speaking a primary language other than English, and people with disabilities and chronic or unusual medical needs will be met.

(k) The remaining need for a safety net health care system for persons not served by certified private health plans, including the role of the existing county health care system and of the current obligations defined by Section 17000 of the Welfare and Institutions Code, once the universal health program is fully implemented.

(*l*) The mechanisms for consolidating the health care

components of workers' compensation and automobile insurance with the health coverage provided under the universal health program, considering the effect of any proposal on workers' current entitlements.

(m) The role of teaching hospitals, medical education, and medical research in the California Health Plan, and the appropriate means of financing these functions.

(n) The appropriate roles of the regional health insurance purchasing corporations and the statewide commission in collecting data for both quality assurance and cost containment, in developing or disseminating medical practice parameters, and in guiding the proliferation of new medical technologies.

(o) Options for phasing in the universal health program described in this division.

20034. On or before July 1, 1994, the commission shall study, and report to the Legislature concerning, the means by which Californians' need for long-term care services can best be met. The commission shall make recommendations concerning the role of long-term care services in the California Health Plan, including the feasibility of including universal, comprehensive access to home, community-based, and institutional services, the feasibility of taking incremental steps toward provision of comprehensive long-term care, the recommended means for financing long-term care, and the appropriate role of the federal and state governments and of private insurance in addressing Californians' long-term care needs.

SEC. 5. There is hereby appropriated from the ~~General~~ *Insurance* Fund to the California Health Plan Commission the sum of ~~one million dollars ($1,000,000)~~ *two hundred fifty thousand dollars ($250,000)* for the 1992–93 fiscal year, to carry out the purposes of Division 9 (commencing with Section 20000) of the Insurance Code. *In addition to the appropriation made by this section, the California Health Plan Commission may receive funds in the form of grants and gifts from private, nonprofit, or other public agencies.*

SEC. 6. Nothing in this act shall be construed to

create any entitlement to health care coverage for any person until such time as the Legislature shall appropriate, pursuant to all applicable law, the funds necessary to implement the program of universal health care coverage described by this act and until such time as the Legislature declares that the program shall be operative.

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AMENDED IN SENATE JULY 2, 1992

AMENDED IN SENATE FEBRUARY 27, 1992

AMENDED IN SENATE JULY 18, 1991

AMENDED IN ASSEMBLY APRIL 15, 1991

CALIFORNIA LEGISLATURE—1991-92 REGULAR SESSION

ASSEMBLY BILL No. 2001

Introduced by Assembly Member Brown
(Principal coauthor: Senator Maddy)

March 8, 1991

~~An act to add Section 3700.2~~ *An act to add Sections 1871.5, 1871.6, and 1871.7 to the Insurance Code, to amend Section 3700 of, to add Sections 3700.2, 3762, and 4609* to, and to add Chapter 1.5 (commencing with Section 2445) to Part 9 of Division 2 of, the Labor Code, and to add Sections 17053.21 and 23615.1 to the Revenue and Taxation Code, relating to health coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2001, as amended, Brown. Health coverage.

(1) Under existing law, certain false or fraudulent acts done in connection with a claim for workers' compensation are a crime.

This bill would, in addition, provide a civil penalty for those acts and related acts.

Under existing law, it is a crime to offer or receive compensation for referring clients or patients for services or benefits pursuant to the workers' compensation laws, with certain exceptions.

This bill would also make it unlawful and impose a civil penalty for employing runners, cappers, or steerers in that connection. It would permit the Attorney General to bring

that civil action, and also permit the action to be brought by an interested person, subject to various restrictions.

The bill would require the Insurance Commissioner to establish a system for the issuance of fines to enforce the above provisions. The fines would be deposited into the Workers' Compensation Fraud Account in the Insurance Fund.

(2) Existing law establishes the Tucker Health Care Coverage Act of 1989, which authorizes every employer, as defined, to provide health care coverage with prescribed benefits to each employee, as defined, in a certain manner.

This bill would enact the Affordable Basic Health Care Act of 1992. Under the act, every employer, as defined, not exempt, as specified, would be required to provide basic health care coverage, as defined, to each employee, as defined, and dependent, as defined, including payment of at least 75% of the lowest premium, as defined, for basic health care coverage the employer offers each covered employee and dependent of a covered employee, basic health care coverage to each employee and his or her dependents, and prescribed continuation of payments for health care for any employee, and his or her dependent, who is hospitalized or otherwise prevented by sickness or injury from working and earning wages and for whom sick leave benefits are exhausted. The bill would limit the employee's contribution to either the difference between the premium and 75% of the lowest premium, or 2% of the employee's wages, as prescribed, whichever is less.

The bill would require all health insurers, as defined, to offer to all employers with 100 employees or fewer, within the service area of the health insurer, basic health care coverage. The bill would require the health insurer to charge a single community rate, as defined, in the same geographic region for basic health care coverage, except that the premium rate offered to those employers would be prohibited from exceeding by more than 30% the community rate for basic health care coverage in the same geographic region, as described. The bill would exempt a health insurer from any law mandating benefits or mandating the offering of benefits to the extent the health insurer is offering to provide or is

providing basic health care coverage, except as required by the bill.

The bill would establish the Health Care Coverage Commission with a prescribed membership and duties.

The bill would require the commission, on or before January 1, 1996, to file a comprehensive report with the Legislature, including a specific legislative proposal (a) to establish a pooling mechanism to provide basic health care coverage for every employee and dependent of an employee, including certain part-time employees, to take effect, if enacted, on or before January 1, 1997; and (b) to establish a mechanism to provide basic health care coverage for every person not otherwise covered by a private health plan, Medicare, or Medi-Cal, to take effect, if enacted, on or before January 1, 1998.

The bill would require the commission to make available to employers with 25 employees or fewer, a minimum of 6 regional small employer health benefits purchasing pools, as described.

The bill would require the Governor to appoint a Medical Policy Panel, Cost Containment Panel, and Technology Panel, with prescribed membership and duties, including advising the commission.

The bill would require the commission to determine the percentage of employers that voluntarily extend coverage equal to or greater than the coverage provided under the act, and, if the commission determines that at least 90% of the employers have voluntarily extended coverage prior to a certain date, the provisions of the act would be inoperative with respect to employers.

The bill would require the commission to provide adequate funding and administrative support for the Medical Policy Panel, for the Cost Containment Panel, and for the Technology Panel.

The bill would, commencing July 1, 1996, require general acute care hospitals to reduce rates, and private carriers to reduce premiums, to reflect cost savings, as specified, and would require the commission to monitor these reductions to ensure the reductions are reflected in purchaser rates and premiums.

(3) Existing law requires every employer except the state to secure the payment of workers' compensation through specified methods.

This bill would, in addition, provide that an employer may secure payment of workers' compensation by obtaining a 24-hour health insurance policy, as specified, that meets the requirements of the workers' compensation laws and the criteria established by the Department of Insurance.

This bill would authorize any employer or association of employers, in complying with the requirements described in (2), to provide health care coverage and the obligation to provide health benefits for workers' compensation coverage in the same contract or policy. The bill would authorize any carrier to provide that consolidated coverage.

(4) Existing law requires insurers to be admitted to do business in this state.

This bill would require, as a condition of licensure, that workers' compensation insurers have a utilization review plan that has been approved by the Insurance Commissioner, as specified.

(5) Existing workers' compensation law requires the employer to provide medical, surgical, chiropractic, and hospital treatment that is reasonably required to cure or relieve the effects of an employee's injury.

This bill would provide that it is unlawful for any person who is a health care provider, as defined, to charge, bill, or otherwise solicit payment on behalf of, or refer a patient to, a facility for certain services paid under the workers' compensation laws, if the provider or the provider's immediate family, has an ownership interest in that facility, unless the provider furnishes to the patient a written disclosure as described. The bill would impose similar restrictions on acute care hospitals. Since a violation would be a public offense, the bill would impose a state-mandated local program.

(6) Existing law provides for certain employer tax credits.

This bill would allow an employer, as defined, providing basic health care coverage under prescribed conditions to receive the credits.

(7) The bill would provide that certain of its provisions

shall become operative on January 1, 1994, or 90 days after the effective date of federal legislation that exempts a portion of the bill from preemption by the federal Employee Retirement Income Security Act of 1974, whenever is later.

(8) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~(1) Existing law establishes the Tucker Health Care Coverage Act of 1989, which authorizes every employer, as defined, to provide health care coverage with prescribed benefits to each employee, as defined, in a certain manner.~~

~~This bill would enact the Affordable Basic Health Care Act of 1992. Under the act, every employer, as defined, not exempt, as specified, would be required to provide basic health care coverage, as defined, to each employee, as defined, and dependent, as defined, including payment of at least 75% of the lowest premium, as defined, for basic health care coverage the employer offers each covered employee and dependent of a covered employee, basic health care coverage to each employee and his or her dependents, and prescribed continuation of payments for health care for any employee, and his or her dependent, who is hospitalized or otherwise prevented by sickness or injury from working and earning wages and for whom sick leave benefits are exhausted.~~

~~The bill would require all health insurers, as defined, to offer to all employers with 100 employees or fewer, within the service area of the health insurer, basic health care coverage. The bill would require the health insurer to charge a single community rate, as defined, in the same geographic region for basic health care coverage, except that the premium rate offered to those employers would be prohibited from exceeding by more than 30% the community rate for basic health care coverage in the same geographic region, as described. The bill would exempt a health insurer from any law mandating benefits or mandating the offering of benefits to the extent the health insurer is offering to provide or is~~

providing basic health care coverage, except as required by the bill.

The bill would establish the Health Care Coverage Commission with a prescribed membership and duties.

The bill would require the commission, on or before January 1, 1996, to file a comprehensive report with the Legislature, including a specific legislative proposal (a) to establish a pooling mechanism to provide basic health care coverage for every employee and dependent of an employee, including certain part/time employees, to take effect, if enacted, on or before January 1, 1997, and (b) to establish a mechanism to provide basic health care coverage for every person not otherwise covered by a private health plan, Medicare, or Medi/Cal, to take effect, if enacted, on or before January 1, 1998.

The bill would require the commission to make available to employers with 25 employees or fewer, a minimum of 6 regional small employer health benefits purchasing pools, as described.

The bill would require the Governor to appoint a Medical Policy Panel, Cost Containment Panel, and Technology Panel, with prescribed membership and duties, including advising the commission.

The bill would require the commission to determine the percentage of employers that voluntarily extend coverage equal to or greater than the coverage provided under the act, and, if the commission determines that at least 90% of the employers have voluntarily extended coverage prior to a certain date, the provisions of the act would be inoperative with respect to employers.

(2) Existing law requires every employer except the state to secure the payment of workers' compensation.

This bill would authorize any employer or association of employers, in complying with the requirements described in (1), to provide health care coverage and the obligation to provide health benefits for workers' compensation coverage in the same contract or policy. The bill would authorize any carrier to provide that consolidated coverage.

(3) Existing law provides for certain employer tax credits.

This bill would allow an employer providing basic health

~~care coverage under prescribed conditions to receive the credits.~~

~~(4) The bill would provide that its provisions shall become operative on the day federal legislation is enacted that exempts the bill from preemption by the federal Employee Retirement Income Security Act of 1974, but in no case before January 1, 1993.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

~~SECTION 1. It is the intent of the Legislature to~~

SECTION 1. It is the intent of the Legislature to ensure access to affordable medically necessary health care to all the people of California by the year 2000.

SEC. 2. The Legislature finds and declares all of the following:

(a) Over 6,000,000 people in California have no health care coverage. Approximately two-thirds of these people are employed or are dependents of employed persons. Most of these people are working at jobs where health care coverage is not provided and at wages which make it impracticable for them to purchase private health care coverage.

(b) State and local governments have provided, and must continue to provide, a health care system to serve indigent and low-income persons. It is the intent of the Legislature that the public safety net institutions shall have sufficient revenue to remain economically viable and to provide care that is fully equal to community standards. However, because of public revenue constraints at both the state and local level, the ability of that system to meet California's need to make health care accessible to its uninsured is wholly inadequate.

(c) The lack of health care coverage for large numbers of Californians is causing the following very serious problems:

(1) Decreasing access to inpatient care, prenatal care, and outpatient care for the uninsured, and decreasing

availability of emergency and trauma care for all Californians.

(2) A greater incidence of marginal to poor health, restricted activity days, birth defects and lifelong disabilities, uncontrolled diabetes and hypertension, and untreated chronic conditions.

(3) Increasingly severe financial problems among those health care providers who continue to care for persons without health coverage, potentially resulting in the closing of emergency departments, trauma centers and hospitals, and the reduction in the availability of health care professionals so as to substantially worsen the quality of health care available to the citizens of this state.

(4) Steadily increasing health care costs and health insurance premiums for the decreasing number of consumers who pay full charges for health services.

(d) The only practical way of making affordable, quality health care available to everyone in California is to maximize the availability of employer-sponsored health care coverage, strengthen the public safety net, and ensure that all parties assume responsibility for containing health care costs, including health care providers, insurers and health care plans, consumers, employers, and government. This will permit the provision of health care through a pluralistic, market-oriented health care system, strengthened by balanced incentives, roles and responsibilities among payors, providers, patients, and government.

(e) The health delivery system in the State of California is on the verge of collapse as a result of the high demand for health care services, the lack of affordable health care coverage, and the increasing burden of uncompensated and undercompensated care. The remedy provided herein is the only adequate and reasonable remedy within the limits of what the foregoing public health safety considerations permit now and into the forseeable future.

SEC. 3. Section 1871.5 is added to the Insurance Code, to read:

1871.5. (a) In enacting Sections 1871.5 to 1871.7,

inclusive, the Legislature declares that there exists a compelling interest in eliminating fraud in the workers' compensation system. The Legislature recognizes that the conduct prohibited by these sections is, for the most part, already subject to criminal penalties pursuant to other provisions of law. However, the Legislature finds and declares that the addition of civil money penalties and, in the case of the most pervasive cause of fraud in the system, employment of runners, cappers, and steerers, the addition of a qui tam action, will provide necessary enforcement flexibility. The Legislature, in exercising its plenary authority related to workers' compensation, declares that these sections are both necessary and carefully tailored to combat the fraud and abuse that is rampant in the workers' compensation system.

(b) It is unlawful to do any of the following:

(1) Make or cause to be made any knowingly false or fraudulent material statement or material misrepresentation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.

(2) Present or cause to be presented any knowingly false or fraudulent written or oral material statement in support of, or in opposition to, any claim for compensation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.

(3) Knowingly solicit, receive, offer, pay, or accept any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for soliciting or referring clients or patients to perform or obtain services or benefits pursuant to Division 4 (commencing with Section 3200) of the Labor Code unless the payment or receipt of consideration for services other than the referral of clients or patients is lawful pursuant to Section 650 of the Business and Professions Code or expressly permitted by the Rules of Professional Conduct of the State Bar.

(4) Knowingly operate or participate in a service that, for profit, refers or recommends clients or patients to perform or obtain medical or medical-legal services or benefits pursuant to Division 4 (commencing with Section 3200) of the Labor Code.

(5) Disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, for the purpose of inducing or likely to induce, directly or indirectly, a client or patient to perform or obtain services or benefits pursuant to Division 4 (commencing with Section 3200) of the Labor Code. A "public communication" as used in this section includes, but is not limited to, communication by means of television, radio, motion picture, newspaper, handbill, newsletter, book, list, or directory. A false, fraudulent, misleading, or deceptive statement includes a statement that does any of the following:

(A) Contains a misrepresentation of fact.

(B) Is likely to mislead or deceive because of a failure to disclose material facts.

(C) Is intended or is likely to create false or unjustified expectations of lawfully obtaining benefits pursuant to Division 4 (commencing with Section 3200) of the Labor Code.

(D) Contains other representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

(6) Knowingly assist, abet, solicit, or conspire with any person who engages in an unlawful act under this section.

(c) For the purposes of this section, "statement" includes, but is not limited to, any notice, proof of injury, bill for services, payment for services, hospital or doctor records, X-ray, test results, medical-legal expenses as defined in Section 4620 of the Labor Code, or other evidence of loss, expense, or payment.

(d) Every person who violates any provision of this section shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not less than two thousand dollars ($2,000) nor more than five thousand dollars ($5,000), plus an assessment of not more

than three times the amount of each claim for compensation, as defined in Section 3207 of the Labor Code, submitted in violation of this section.

(e) Any person who violates subdivision (b) and who has a prior felony conviction of an offense set forth in Section 1871.1 or 1871.4, or in Section 549 of the Penal Code, shall be subject, in addition to the penalties set forth in subdivision (d), to a civil penalty of two thousand dollars ($2,000) for each item or service with respect to which a violation of subdivision (b) occurred.

SEC. 4. Section 1871.6 is added to the Insurance Code, to read:

1871.6. (a) The commissioner shall establish, by regulation, a system for the issuance of fines to enforce Sections 1871.5 and 1871.7.

(b) The system shall contain the following provisions:

(1) Notice of the violation and fine shall be in writing and shall describe with particularity the nature of the violation, including specific reference to the provision of law determined to have been violated. The notice shall be served in person or by certified mail at the last address of record of the person cited.

(2) In assessing a fine, due consideration shall be given to the appropriateness of the amount of the fine with respect to factors including the gravity of the violation, the good faith of the person committing the violation, and the history of previous violations.

(3) The notice shall inform the person that if the person desires a hearing to contest the finding of a violation, that hearing must be requested by written notice within 30 days of the date of issuance of the notice of violation. Hearings shall be held pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Fines collected pursuant to this section shall be deposited in the Workers' Compensation Fraud Account in the Insurance Fund and shall be used solely for the purpose of reducing the amount of the assessment on employers imposed pursuant to subdivision (b) of Section 1872.83.

(d) In an action for judicial review of a fine imposed pursuant to this section, the court shall award to a prevailing party, other than the state or its agencies, reasonable attorneys' fees and expenses unless the court finds that the position of the state was substantially justified or that special circumstances make the award unjust.

SEC. 5. Section 1871.7 is added to the Insurance Code, to read:

1871.7. (a) It is unlawful to knowingly employ runners, cappers, steerers, or other persons to procure clients or patients to perform or obtain services or benefits pursuant to Division 4 (commencing with Section 3200) of the Labor Code.

(b) Every person who violates any provision of this section shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000), plus an assessment of not more than three times the amount of each claim for compensation, as defined in Section 3207 of the Labor Code, submitted in connection with violation of this section.

(c) Any person who violates subdivision (a) and who has a prior felony conviction of an offense set forth in Section 1871.1 or 1871.4, or in Section 549 of the Penal Code, shall be subject, in addition to the penalties set forth in subdivision (b), to a civil penalty of five thousand dollars ($5,000) for each item or service with respect to which a violation of subdivision (a) occurred.

(d) The Attorney General or any district attorney may bring a civil action under this section.

(e) (1) Any interested persons may bring a civil action for a violation of this section for the person and for the State of California. The action shall be brought in the name of the state. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the

person possesses shall be served on the state. The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Attorney General may elect to intervene and proceed with the action within 60 days after he or she receives both the complaint and the material evidence and information.

(3) The Attorney General may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). The motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 20 days after the complaint is unsealed and served upon the defendant.

(4) Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the Attorney General shall either:

(A) Proceed with the action, in which case the action shall be conducted by the Attorney General.

(B) Notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person brings an action under this section, no person other than the Attorney General or any district attorney may intervene or bring a related action based on the facts underlying the pending action.

(f) (1) If the Attorney General proceeds with the action, he or she shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. That person shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (2).

(2) (A) The Attorney General may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Attorney General of the filing of the motion, and the court has provided the person with an opportunity for a hearing on the motion.

(B) The Attorney General may settle the action with

the defendant notwithstanding the objections of the person initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, the hearing may be held in camera.

(C) Upon a showing by the Attorney General that unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the Attorney General's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the person's participation, including, but not limited to, the following:

(i) Limiting the number of witnesses the person may call.

(ii) Limiting the length of the testimony of such witnesses.

(iii) Limiting the person's cross-examination of witnesses.

(iv) Otherwise limiting the participation by the person in the litigation.

(D) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the person in the litigation.

(3) If the Attorney General elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the Attorney General so requests, he or she shall be served with copies of all pleadings filed in the action and shall be supplied with copies of all deposition transcripts, at the Attorney General's expense. When a person proceeds with the action, the court, without limiting the status and rights of the person initiating the action, may nevertheless permit the Attorney General to intervene at a later date upon a showing of good cause.

(4) Whether or not the Attorney General proceeds

with the action, upon a showing by the Attorney General that certain actions of discovery by the person initiating the action would interfere with the Attorney General's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay this discovery for a period of not more than 60 days. A hearing on a request for the stay shall be conducted in camera. The court may extend the 60-day period upon a further showing in camera that the Attorney General has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(5) Notwithstanding subdivision (e), the Attorney General may elect to pursue its claim through any alternate remedy available to the Attorney General. If any alternate remedy is pursued in another proceeding, the person initiating the action shall have the same rights in that proceeding as the person would have had if the action had continued under this section. Any finding of fact or conclusion of law made in the other proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of the preceding sentence, a finding or conclusion is final if it has been finally determined on appeal to the appropriate court, if all time for filing an appeal with respect to the finding or conclusion has expired, or if the finding or conclusion is not subject to judicial review.

(g) (1) If the Attorney General proceeds with an action brought by a person under subdivision (e), that person shall, subject to the second sentence of this paragraph, receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent that the person substantially contributed to the prosecution of the action. Where the action is one that the court finds to be based primarily on disclosures of specific information, other than information provided by the person bringing the action, relating to allegations or transactions in a criminal, civil, or administrative hearing, in a legislative or

administrative report, hearing, audit, or investigation, or from the news media, the court may award a sum as it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person under the first or second sentence of this paragraph shall be made from the proceeds. This person shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All of those expenses, fees, and costs shall be awarded against the defendant.

(2) If the Attorney General does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount that the court decides is reasonable for collecting the civil penalty and damages. The amount shall not be less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of the proceeds. That person shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All of those expenses, fees, and costs shall be awarded against the defendant.

(3) Whether or not the Attorney General proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of this section, that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. The dismissal shall not prejudice the right of the Attorney General to continue the action on behalf of the state.

(4) If the Attorney General does not proceed with the action, and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that the claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of

harassment.

(h) (1) In no event may a person bring an action under subdivision (e) that is based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the Attorney General or any district attorney is already a party.

(2) (A) No court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing in a legislative or administrative report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or a district attorney or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, "original source" means an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Attorney General or a district attorney before filing an action under this section which is based on the information.

(i) The Attorney General or district attorney is not liable for expenses that a person incurs in bringing an action under this section.

(j) In civil actions brought under this section by the Attorney General, the court shall award to a prevailing defendant reasonable attorneys' fees and expenses unless the court finds that the position of the Attorney General was substantially justified or that special circumstances make an award unjust.

(k) Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make

the employee whole. That relief shall include reinstatement with the same seniority status the employee would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An employee may bring an action in the appropriate superior court for the relief provided in this subdivision.

(l) The remedies provided by this section are cumulative to the remedies available under all other laws of this state.

SEC. 6. Chapter 1.5 (commencing with Section 2445) is added to Part 9 of Division 2 of the Labor Code, to read:

CHAPTER 1.5. AFFORDABLE BASIC HEALTH CARE ACT OF 1992

Article 1. Title and Operative Dates

2445. This chapter shall be known and may be cited as the Affordable Basic Health Care Act of 1992.

2445.2. Except for provisions within this chapter that specify a later operative date, this chapter shall become operative on January 1, 1993, except that Article 3 (commencing with Section 2455), Article 4 (commencing with Section 2460), and Article 5 (commencing with Section 2464) shall not be operative until January 1, 1994, or 90 days after the effective date of federal legislation that exempts Article 3 (commencing with Section 2455) from preemption by the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001 et seq.), whichever occurs later. In the event the effective date of federal legislation that exempts Article 3 (commencing with Section 2455) from preemption by the federal Employee Retirement Income Security Act of 1974 occurs after October 3, 1993, then all the dates in this chapter shall be extended for a period of time equal to the number of days between October 3, 1993, and the effective date of the federal

legislation. In no case shall Article 3 (commencing with Section 2455), Article 4 (commencing with Section 2460), or Article 5 (commencing with Section 2464), become operative if federal legislation as specified in this section is not enacted or does not take effect.

Article 2. Definitions

2445.5. Unless the context requires otherwise, the definitions set forth in this article shall govern the construction and meaning of the terms and phrases used in this chapter.

2446. "Basic health care coverage" means a health plan that provides basic health care services as set forth in this chapter.

2446.5. "Carrier" means any insurer, health care service plan, nonprofit hospital service plan, self-funded employer-sponsored plan, multiple employer trust, multiple employer welfare arrangement as defined by federal law (29 U.S.C. Sec. 1002(40)(A)), Taft-Hartley Trust as defined by federal law (42 U.S.C., Sec. 186), or other entity that writes, issues, administers, provides, or pays for, health care services in this state.

2447. "Catastrophic health care coverage" means a health plan that provides coverage for catastrophic health care expenses as defined by the commission.

2447.5. "Commission" means the Health Care Coverage Commission.

2447.6. "Community rate" means the premium determined for basic health care coverage in each geographic region on a per person or per family basis and may vary with the number of persons in a family, but the premium shall be equivalent for all individuals and for all families of similar composition, regardless of the sex, occupation, or other factor that has, or might, affect the cost of providing services to an enrollee, other than age.

2448. "Cost-sharing" means any deductible, copayment, coinsurance, or any other mechanism other than a premium payment whereby an employee pays for a portion of the cost of health services provided to the

employee or the employee's dependent.

2448.5. "Dependent" means the spouse, child, or adopted child up to age 22 and permanently disabled child of the covered employee.

2449. "Employee" means any person who works at least 25 hours per week or 108 hours per month for any single employer in a bona fide employer-employee relationship, more than 60 days in any calendar year. "Employee" shall not include an independent contractor or any registered student in a postsecondary educational institution who is working for the institution and who is covered by student health services sponsored by the institution.

2449.5. "Employer" means any person, partnership, corporation, association, joint venture or public or private entity employing for wages or salary 25 or more employees at any one time to work in this state. Effective January 1, 1995, "employer" means any person, partnership, corporation, association, joint venture or public or private entity employing for wages or salary 10 or more employees at any one time to work in this state. Effective January 1, 1996, "employer" means any person, partnership, corporation, association, joint venture or public or private entity employing for wages or salary five or more employees at any one time to work in this state. Effective January 1, 1997, "employer" means any person, partnership, corporation, association, joint venture or public or private entity employing for wages or salary one or more employees at any one time to work in this state.

2451. "Enrollee" means each individual with at least basic health care coverage.

2451.5. "Health insurer" means any insurer, health care service plan, or entity that writes, issues, administers, provides, or pays for health care services in this state and that is regulated by the Department of Corporations or the Department of Insurance.

2452. "Health plan" means a program providing health care services directly or through insurance, reimbursement or otherwise.

2452.5. "Pool" means a regional small employer

health benefits purchasing pool as set forth in Section 2482.5.

2452.6. "Practice parameter" means a strategy for patient management developed to assist physicians, in clinical decisionmaking, and includes standards, guidelines, and other patient management strategies. Only practice parameters that have been developed in conformance with the "Attributes to Guide the Development of Practice Parameters" published by the American Medical Association/Specialty Society Practice Parameters Partnership may be approved by the commission pursuant to subdivision (e) of Section 2480.5.

2453. "Premium" means the monthly per enrollee amount that the carrier charges for providing basic health care coverage, or for self-insured plans, the monthly per enrollee amount that the Health Care Coverage Commission determines to be the actuarially sound cost of the basic health care coverage, or for carriers providing partial insurance to self-insured plans, the total of the monthly per enrollee amount which the carrier charges for providing basic health care coverage and the monthly per enrollee amount that the Health Care Coverage Commission determines to be the actuarially sound cost of the self-insured portion of the basic health care coverage.

2453.5. "Supplemental policy" means health care coverage for services not included in the basic health care coverage as provided by Article 4 (commencing with Section 2460).

2454. "Wages" means all remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by his or her employer or a customer.

Article 3. Employee Health Care Coverage

2455. On and after January 1, 1994, every employer shall provide basic health care coverage to each employee and his or her dependents, including all of the following:

(a) Payment of at least 75 percent of the lowest premium for basic health care coverage the employer offers for each covered employee and dependent of a covered employee.

(b) Basic health care coverage to every employee and his or her dependents, effective no later than the first day of the calendar month following the employee's 60-day anniversary.

(c) Continuation of payments for health care coverage for any employee who is hospitalized or otherwise prevented by sickness or injury from working and earning wages, and for whom sick leave benefits are exhausted, and for the dependents of the employee. This obligation shall continue for three calendar months following the month during which the employee became hospitalized or disabled from working, or until the month the employee becomes eligible for other public or private coverage, whichever occurs first.

(d) The commission may delay the phase-in of employer coverage by no more than two years for employers with fewer than 25 employees if the commission determines that the economic condition of the state would place an undue hardship on those employers.

2455.5. (a) No new employer shall be required to provide basic health care coverage until 27 months after the date the new employer first received an employer tax identification number from the Employment Development Department. The commission shall adopt regulations designed to ensure that this exemption applies only to bona fide start-up enterprises and not to businesses resulting from the sale, reorganization, or other alteration of an existing enterprise.

(b) A new employer may waive the exemption set forth in subdivision (a) by submitting a written waiver on a form prescribed by the Franchise Tax Board.

2456. Nothing in this chapter shall be construed to limit the right of employees to bargain collectively for different health care coverage, if the protection provided by the negotiated plan is at least actuarially equivalent to

the protection afforded by this chapter. This chapter shall be applicable with respect to any employees who do not receive at least this level of protection or who are not covered by the health care provisions of the applicable collective bargaining agreements to which their employer is a party.

2456.5. An employer shall not be required to provide health care coverage pursuant to this article with respect to any employee or dependent if the employee waives enrollment of the employee or the employee's dependent in writing pursuant to Section 2458.

2457. An employer shall deduct from the wages owed to any employee the amount sufficient to cover the employee's contribution, if any, to the premium required by Section 2457.5.

2457.5. The employee's contribution shall be the portion of the premium not covered by the employee's employer or the commission, if any. However, an employee shall not be required to pay more than the lesser of either of the following:

(a) The difference between the premium and 75 percent of the lowest premium for basic health care coverage offered by the employer.

(b) Two percent of the employee's wages for employee and dependent coverage. This subdivision shall apply only to the lowest premium for basic health care coverage that the employer offers.

2458. (a) An employee shall not waive basic health care coverage for the employee or the employee's dependents except as provided in this section, that requires an employee to waive basic health care coverage as necessary to avoid duplicate coverage. The employee shall have the right to elect what coverage to waive should a waiver be required by this section.

(b) An employee that has basic health care coverage for the employee or his or her dependents, or both, shall waive any duplicate coverage, but only for the period that the employee or the dependent, or both, has at least basic health care coverage.

(c) A dependent minor who is employed, or a parent

or guardian on the behalf of a dependent minor under 12 years of age, shall waive basic health care coverage provided by the dependent minor's employer, but only if and for the period that the dependent minor, or parent or guardian on behalf of the dependent minor, has at least basic health care coverage.

(d) If an individual is an employee of more than one employer, the employee shall waive basic health care coverage from all but one employer so that the employee and each dependent has only one basic health care coverage.

(e) An employee who waives health care coverage pursuant to this section shall notify his or her employer immediately if the duplicate coverage is terminated, and shall enroll in the employer's health care plan effective not later than the first day of a calendar month following 30 days from the date of the termination of coverage.

2458.5. An employer shall not fail or refuse to hire, and shall not discharge or otherwise discriminate against, any individual because the individual has a spouse or child or other dependent and the employer would be required by this article to provide basic health care coverage for the spouse or child or other dependent. A violation of this section constitutes unlawful discrimination within the meaning of Section 51 of the Civil Code, and an unfair business practice within the meaning of Section 17200 of the Business and Professions Code.

2459. Any employer who fails to provide basic health care coverage as required by this act shall be liable for twice the health care costs incurred by an employee or that employee's dependent during the period in which the employer failed to provide coverage and the employee's reasonable attorney's fees.

Article 4. Basic Health Care Benefits

2460. Basic health care coverage provided in accordance with this chapter shall include the provision of or payment for all of the following in each calendar

year that are medically necessary for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member of an enrollee, except as otherwise provided in this article:

(a) Hospital inpatient care for a period of at least 45 days in a hospital licensed pursuant to subdivision (a) or (b) of Section 1250 of the Health and Safety Code including all of the following:

(1) Room and board, including private room and special diets when prescribed as medically necessary, and general nursing services.

(2) Hospital services, including use of operating room and related facilities, intensive care unit and services, whole blood and blood derivatives, labor and delivery room, anesthesia, radiology, laboratory, and other diagnostic services.

(3) Drugs and medications administered while an inpatient.

(4) Dressings, casts, equipment, oxygen services, and radiation therapy.

(5) Respiratory and physical therapy following prior authorization.

(b) Medical and surgical services, that shall be provided on an outpatient basis when medically appropriate, including all of the following:

(1) Surgical services.

(2) Radiology, nuclear medicine, ultrasound, laboratory, and other diagnostic services.

(3) Dressings, casts and use of castroom, anesthesia and oxygen services when medically necessary.

(4) Blood derivatives and their administration, and whole blood when a volunteer blood program is not available to the enrollee.

(5) Hospital visits, and at least 20 home or office visits.

(6) Radiation therapy and chemotherapy of proven benefit.

(7) Pap smears and mammograms under the periodicity schedules approved by the commission.

(8) Medical and surgical consultation.

(9) Sterilization, but not including sex change

operations, investigation of or treatment for infertility, reversal of sterilization, conception by artificial means, and contraceptive supplies and devices.

(c) Comprehensive maternity and perinatal care.

(d) Emergency and necessary followup care, including emergency ambulance transportation.

(e) Long-term care benefits, including home care, skilled nursing care, respite, and hospice care, to the extent the carrier determines they are less costly alternatives to covered inpatient care.

(f) Plastic and reconstructive services limited to the following:

(1) To correct a physical functional disorder resulting from a congenital disease or anomaly.

(2) To correct a physical functional disorder following an injury or incidental to surgery covered by the basic health care coverage.

(3) For reconstructive surgery and associated procedures following a mastectomy that resulted from disease, illness, or injury. Internal breast prostheses required incidental to the surgery shall be provided.

(g) Child preventive care including periodic routine physical examinations, and proven preventive procedures, immunizations, vaccinations, and screenings for well children in accordance with the Guidelines for Health Supervision of Children and Youth as adopted by the American Academy of Pediatrics in September 1987.

(h) Mental health benefits, including both of the following or their actuarial equivalent:

(1) Inpatient care or acute residential care for a period of at least 15 days in each calendar year.

(2) At least 20 outpatient visits in each calendar year.

(i) At least 10 outpatient visits in each calendar year for speech, occupational, and physical therapy.

(j) Durable medical equipment.

(k) Prescription drugs, limited to drugs approved by the federal Food and Drug Administration for approved indications, generic equivalents listed as substitutable in the federal Food and Drug Administration publication, "Approved Drug Products with Therapeutic

Equivalence Evaluation," and those additional nonapproved indications as approved by the commission pursuant to Section 2480.5.

(l) Nothing in this chapter shall be construed as expanding or restricting the scope of practice conferred upon any person licensed, certified, or registered pursuant to the Business and Professions Code or licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act.

2460.2. All mental health services provided under this chapter shall be subject to appropriate utilization review, confirmation of diagnosis, and quality assurance mechanisms designed to ensure the proper administration of these benefits.

2460.5. Basic health care coverage provided in accordance with this chapter shall not include any of the following:

(a) Anything that is either of the following:

(1) Not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question.

(2) Determined by the commission to be outmoded, not efficacious, outside a practice parameter, or not sufficiently cost-effective pursuant to paragraph (7) of subdivision (a) of Section 2480.5.

(b) Implants, except pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips.

(c) Eyeglasses, contact lenses (except lenses for keratoconus, or following cataract surgery, or corneal transplantation), radial or hexagonal keratotomy, routine eye examinations, including eye refractions, except provided as part of a routine examination under "preventive care," hearing aids, orthopedic shoes, orthodontic appliances, and routine foot care.

(d) Prescription and nonprescription drugs, except those provided as an inpatient hospital benefit and as specified in subdivision (k) of Section 2460. Any exclusion of drugs and medicines also excludes their

administration.

(e) Treatment of chemical dependency, except for acute inpatient detoxification.

(f) Obesity treatment or weight loss programs.

(g) Health care services received from or paid for by the Veterans' Administration, benefits paid under any workers' compensation or any employers' liability law or federal law for injury or illness, or any accident insurance.

(h) Conditions resulting from acts of war whether declared or not.

(i) Any service or supply not specifically listed as a covered service or supply.

2461. Notwithstanding Sections 2460 and 2460.5, health plans meeting the minimum requirements for benefits mandated for federally qualified health maintenance organizations or for health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) that provide at least the basic health care coverage specified in Section 2460 shall be deemed to constitute basic health care coverage as long as they otherwise comply with the requirements of this chapter.

2461.5. (a) Basic health care coverage may include provisions for cost sharing if the cost sharing is the same as or actuarially equivalent to all of the following:

(1) The employee's total annual out-of-pocket expenses for copayments and deductibles shall not exceed one-quarter of the annual premium for the employee and the employee's dependents, if any.

(2) Deductibles shall not exceed two hundred fifty dollars ($250) annually for an individual or five hundred dollars ($500) annually for a family, adjusted annually by a percentage equal to the percentage change, if any, in the federal minimum wage commencing January 1, 1994.

(3) No copayment shall exceed 20 percent of the approved charge of a covered service.

(4) Copayment requirements for biologically based severe mental disorders shall be the same as copayments required for major medical benefits inpatient and

outpatient benefits, if any. The biologically based severe mental disorders included in this section shall include schizophrenic disorders, delusional disorders, other psychotic disorders, bipolar mood disorders, major depressive disorders with psychotic features or melancholia, and pervasive developmental disorders.

(b) Notwithstanding subdivision (a), basic health care coverage may provide for a deductible for prescription drugs provided on an outpatient basis of up to two hundred dollars ($200) annually for an individual or four hundred dollars ($400) for a family, adjusted annually by a percentage equal to the percentage change, if any, in the federal minimum wage commencing January 1, 1994.

(c) Notwithstanding subdivision (a), basic health care coverage shall not include any provision for cost sharing with respect to pap smears and mammograms as specified in paragraph (7) of subdivision (b) of Section 2460, child preventive care as specified in subdivision (g) of Section 2460, or maternity and perinatal care as specified in subdivision (c) of Section 2460.

2462. Basic health care coverage may exclude, or provide for a copayment in excess of that set forth in Section 2461.5 for receiving nonemergency services outside of the contracted provider network, or for any item or services that an individual obtains without complying with any reasonable procedures established by the carrier, and approved by the licensing agency of the carrier or authorized by the commission, to ensure the efficient and appropriate utilization of nonemergency covered services, or to encourage or require the use of providers contracting with the carrier for nonemergency services.

2462.5. Basic health care coverage shall not include a lifetime policy limit of less than five hundred thousand dollars ($500,000) per enrollee, and shall not include an annual policy limit of less than the lifetime limit.

2463. Basic health care coverage shall be administered in compliance with the following minimum requirements:

(a) No contract for, or advertising of, basic health care

coverage shall misrepresent the terms of any contract for basic health care coverage.

(b) Claims shall be submitted on the Uniform Claim Form or the Uniform Capitated Health Care Encounter Form, or the equivalent electronic claims submission, approved by the commission.

Article 5. Health Insurers

2464. All health insurers shall offer to all employers, as defined pursuant to Section 2449.5 and any modifications required by subdivision (d) of Section 2455 or by Section 2445.2, with 100 employees or less within the service area of the health insurer a basic health care coverage option. Health insurers shall charge a single community rate in the same geographic region for basic health care coverage, except that the premium rate offered to any employer with 100 employees or less shall not exceed that insurer's community rate for basic health care coverage in that geographic region by more than 30 percent. Geographic underwriting standards shall be limited to six California regions as determined by the commission, reflecting geographic variations in practice costs. Health insurers may enter into subcontracts with other entities in carrying out the requirements of this section.

2464.5. Notwithstanding Section 2464, where it maintains a network, a health insurer may cease to offer coverage to employers not already contracting with it if the health insurer reasonably anticipates that it will not have the capacity within its network of associated health providers to deliver services adequately to additional enrollees because of its obligations to existing group contractholders and enrollees. A health insurer that ceases to offer coverage pursuant to this section shall not enroll new groups of employers unless it resumes offering coverage pursuant to Section 2464. Any health insurer that offers health care coverage shall accept every employer with 100 employees or fewer that requests a rate quote and accepts the rate quote received, provided the employer complies with the requirements of the

group contract or policy.

2465. Carriers shall not exclude or otherwise limit any individual from group coverage under any plan of basic health care coverage on the basis that the individual has, or at any time has had, any disease, disorder, or condition.

2465.5. Coverage accepted by employers shall be renewable with respect to all eligible employees or dependents at the option of the policyholder or contractholder except as follows:

(a) For nonpayment of the required premiums by the policyholder or contractholder.

(b) For fraud or misrepresentation of the policyholder or contractholder.

(c) For material noncompliance with plan provisions.

2466. Carriers shall enroll, not later than the first day of the calendar month following 30 days from the termination date of coverage, any individual who would otherwise be covered by a group coverage and whose duplicate coverage is terminated as set forth in subdivision (d) of Section 2458.

2466.5. To the extent they are offering to provide or are providing basic health care coverage, carriers are exempt from any law mandating benefits or mandating the offering of benefits except as specifically provided in this article.

2467. A carrier may offer and provide health care coverage that exceeds the requirements established for basic health care coverage through a supplemental policy. Sections 2464 to 2466, inclusive, shall apply to the basic health care coverage portion of that coverage, but shall not apply to the supplemental policy providing coverage that exceeds the requirements for basic health care coverage.

2467.3. Carriers that provide basic health care coverage shall make available catastrophic health care coverage to retired employees not eligible for Medicare at rates based on sound actuarial principles, provided, however, that a carrier that is a federally qualified health maintenance organization may meet this requirement by offering basic health care coverage.

2467.5. Any carrier that violates this chapter shall be deemed to have committed a violation of its enabling or licensing statutes, subjecting it to all enforcement actions available to the Insurance Commissioner or Commissioner of Corporations, as applicable. Carriers not subject to the jurisdiction of the Insurance Commissioner or Commissioner of Corporations shall be subject to all the enforcement powers of the commission.

2468. Carriers may combine to establish and participate in a reinsurance program, subject to the requirements established by the commission. Carriers participating in a reinsurance program shall comply with Sections 2464 to 2466, inclusive, but may cede that portion of the risk agreed to by the reinsurance entity to the reinsurance entity. The reinsurance entity shall provide for the proper funding of the program, including actuarially sound reserves for unpaid losses, by charging the member carriers a reinsurance contribution and, as necessary, by assessing and collecting from the member carriers in proportion to their participation in the program. Any unsatisfied net liability or outstanding assessment owed by an insolvent carrier participating in the reinsurance program shall be assumed by and apportioned among the remaining carriers in the reinsurance program in the same manner in which assessments are levied by the reinsurance entity. The reinsurance entity shall have all rights allowed by law on behalf of the remaining carriers against the insolvent carrier for sums due the program.

2468.5. This article shall be binding on carriers only with respect to basic health care coverage offered or provided to employers that are mandated to provide coverage pursuant to Section 2455. Health insurers shall offer basic health care coverage to employers of specific numbers of employees, as defined in Section 2449.5, at the same point in time as employers of those specific numbers of employees are required to provide basic health care coverage for their employees pursuant to Sections 2449.5 and 2455, including, but not limited to, any modifications pursuant to subdivision (d) of Section

2455, or pursuant to Section 2445.2.

Article 7. Health Care for Every Californian

2473. On or before January 1, 1996, the commission shall file a comprehensive report with the Legislature, including a specific legislative proposal, to take effect by January 1, 1997, if enacted, for establishing a pooling mechanism to provide basic health care coverage for all employees in the state, who work 60 days or less in any calendar year, or less than 25 hours per week, or less than 108 hours per month, and for their dependents, to take effect, if enacted, no later than January 1, 1997.

2473.5. On or before January 1, 1997, the commission shall file a comprehensive report with the Legislature, including a specific legislative proposal for establishing a mechanism to provide basic health care coverage for every Californian not otherwise covered by a private health plan, Medicare, or Medi-Cal, to take effect if enacted no later than January 1, 1998.

2474. The commission shall study the feasibility of extending basic health care coverage to every Californian eligible for Medi-Cal. The commission shall report its findings to the Legislature on or before January 1, 1995.

Article 8. Health Care Coverage Commission

2475. There is in state government the Health Care Coverage Commission.

2475.5. The commission shall consist of 12 members, appointed as follows:

(a) Six members appointed by the Governor.

(b) Three members appointed by the Speaker of the Assembly.

(c) Three members appointed by the Senate Committee on Rules.

2476. The members of the commission shall serve for staggered six-year terms. The initial appointments to the commission shall be for the following terms:

(a) The Governor shall appoint two members for

two-year terms, two members for four-year terms, and two members for six-year terms.

(b) The Speaker of the Assembly shall appoint one member for a two-year term, one member for a four-year term, and one member for a six-year term.

(c) The Senate Committee on Rules shall appoint one member for a two-year term, one member for a four-year term, and one member for a six-year term.

(d) The term for each of the initial appointments to the commission shall commence on January 1, 1993.

2476.5. A member whose term has expired shall continue to serve until his or her successor is appointed and qualified.

2477. Appointments to fill vacancies on the commission shall be for the unexpired term.

2477.5. The Legislature shall determine the compensation to be paid to members of the commission. In addition, each member shall be entitled to receive actual expenses incurred in the discharge of his or her duties, including actual and necessary travel expenses.

2478. The members of the commission shall select two of its members to be chairperson and vice chairperson.

2478.5. Seven members of the commission shall constitute a quorum for the transaction of any business, for the performance of any duty, or for the exercise of any power of the commission.

2479. The commission shall appoint an executive officer who shall be exempt from civil service pursuant to subdivision (e) of Section 4 of Article VII of the California Constitution. The executive officer shall serve at the pleasure of the commission.

2479.5. The executive officer shall perform and discharge under the direction and control of the commission, the powers, duties, purposes, functions, and jurisdiction delegated to him or her by the commission.

2480. The commission shall do all of the following:

(a) File a comprehensive report with the Legislature, including a specific legislative proposal for establishing a mechanism to provide sliding-scale subsidies for low-income employees and their dependents. The

commission shall identify savings to existing programs, including, but not limited to, Medi-Cal, that would accrue as a result of full implementation of this act. The commission, after identification of these savings, shall submit to the Governor and the Legislature recommendations for utilization of these savings to offset the cost of health care coverage to low-income employees and small employers.

(b) Establish any requirements the commission determines to be reasonably necessary to maximize the access to necessary health care for those carriers not regulated by the Department of Insurance or the Department of Corporations.

(c) Develop and maintain a method of responding to employers' inquiries relating to general health care coverage options, and provide comparative information on the costs, benefits, and services of all certified basic health care coverage options and those supplemental policies of which the commission is aware.

(d) Collect from carriers and refer to the Medical Policy, Cost Containment, and Technology Panels data on the utilization of health care services . The commission shall require reporting only as necessary to accomplish its purposes with respect to cost containment, access, quality, and control of expensive technology, and shall establish reporting mechanisms designed to minimize the administrative burden and cost to health care providers and carriers. Information that individually identifies patients shall be kept confidential, except as provided pursuant to subdivision (d) of Section 2485.

(e) Monitor the access that California residents have to necessary health care services, determine the extent of any unmet needs for these services or lack of access or quality that may exist from time to time, and make an annual report to the Governor and the Legislature, including recommendations it deems appropriate to maximize the availability of quality health care. The report shall include the major causes of health care cost escalation, including at least the following: insurance administration, cost shifting by government, increased

utilization, increased technology, the tort system, the aging population, biological epidemics, including, but not limited to, AIDS, drug abuse, and tobacco use, and other increases in practice costs. The report shall include a recommendation on the scope of basic health care benefits. Any recommendations for an increase in benefits shall include an explanation of the projected annual financial effect of the amendment expressed both in the aggregate and the amount of increase in the average premium and cost-sharing expense the average employer and employee would bear. The report shall also include recommendations the commission deems appropriate to contain health care costs, and, if the rate of premium increases has not stabilized by the time Article 3 (commencing with Section 2455) has been implemented, a recommendation of the feasibility and advisability of capping future premium increases.

(f) Monitor compliance with this chapter, and report annually to the Legislature its findings and recommendations, including any specific legislative proposal for penalties or other enforcement mechanisms as it finds are warranted.

(g) Develop a uniform claim form for use by all carriers providing basic health care coverage on a fee-for-service basis and a uniform capitated health care encounter form for all carriers providing basic health care coverage on a capitated basis. These forms shall be as similar as possible, and shall include all of the information required to be reported pursuant to subdivision (a) of Section 2480.5.

(h) Provide adequate funding and administrative support for the Medical Policy Panel, the Cost Containment Panel, and for the Technology Panel.

(i) Exercise all powers reasonably necessary to carry out the powers and responsibilities granted or imposed upon it under this chapter.

2480.5. The commission shall adopt pursuant to the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1, of Division 3, of Title 2, of the Government Code), all necessary rules

and regulations to carry out this chapter, including, but not limited to, the following:

(a) Establishing requirements for reporting by carriers of data on the utilization of health care services to the Office of Statewide Health Planning and Development. This data collection system shall meet the following criteria:

(1) Protect the confidentiality of personal and private patient information.

(2) Preserve incentives for physicians to make diagnostic and treatment decisions based on medical necessity rather than cost alone.

(3) Avoid duplication of costs by requiring carriers rather than health care providers to submit data.

(4) Adopt safeguards to ensure that the data collected is interpreted by experienced, practicing physicians and surgeons licensed to practice medicine in California.

(5) Assure that the data collected are valid, useful, and appropriate for comparison.

(6) Afford all interested professional medical and hospital associations a minimum of 30 days to comment before any data is released to the public.

(7) Assure that data collection requirements are adequate but not onerous, cost-effective, and related to a valid and achievable purpose.

(b) Establishing procedures for appealing to the Cost Containment Panel disputes over excessive charges for health care services, as recommended by the Cost Containment Panel. These procedures shall encourage the resolution of these disputes by nonprofit medical and other professional societies that are exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code and are composed of at least 25 percent of the eligible licentiates in the geographic area served by the society.

(c) Determining and adjudicating disputes concerning whether a health care procedure, service, drug, or device is experimental, investigational, outmoded, not efficacious, outside a practice parameter approved pursuant to subdivision (e) or otherwise not

sufficiently cost-effective to be included in basic health care coverage as recommended by the Medical Policy Panel.

(d) Establishing the indications for prescription drugs that, although not approved by the federal Food and Drug Administration, are included in basic health care coverage as recommended by the Medical Policy Panel.

(e) Adopting the practice parameters that may be used by carriers providing basic health care coverage to deny payment as recommended by the Medical Policy Panel. Beneficiaries shall not be required to pay for services denied pursuant to this paragraph.

(f) Determining when the referral by health care providers to facilities in which they have an ownership interest is permitted and when this self-referral is prohibited.

2481. The commission shall hire staff and may contract with any public agency, including any agency of the state government or with any private person, as necessary to carry out its duties.

2482.5. (a) The commission shall make available to employers with 25 employees or fewer a minimum of six regional small employer health benefits purchasing pools. The commission shall contract with a minimum of six private not-for-profit corporations to administer these pools. The contractors shall not be carriers and shall have experience in the administration of health benefits programs or shall have the present or reasonably anticipated capability to administer the pool in a geographic area.

(b) Each contractor shall contract with a minimum of three carriers to make available basic health care coverage pursuant to Article 4 (commencing with Section 2460) and Article 5 (commencing with Section 2464).

(c) The commission shall adopt, pursuant to the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 2 of Title 2 of the Government Code), all rules and regulations necessary to implement the small employer

health benefits purchasing pools, including, but not limited to, the following:

(1) Marketing and recruitment of potential enrollees.

(2) Determining eligibility for pool participation.

(3) Data collection, analysis, and reporting.

(4) Financial solvency of participating carriers.

(5) Methods of collecting premiums and available subsidies.

(d) Employers that participate in a pool shall purchase basic health care coverage for all of its employees and their dependents who have not waived coverage pursuant to Section 2458.

(e) Costs for the administration of the purchasing pools may be borne by carriers that make available basic health care coverage to employers in the pool.

Article 9. Medical Policy Panel

2484. Upon the nomination of the commission, the Governor shall appoint a Medical Policy Panel that shall be composed of seven physicians and surgeons licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act, as set forth in Chapter 8 (commencing with Section 3600) of Division 2 of the Business and Professions Code, and in the active practice of medicine, and one member representing each of the following: hospitals, nursing, labor, business and carriers providing basic health care coverage. The physician panel members shall be nominated by the commission after it has consulted with the statewide and local associations of the medical profession. The person representing hospitals shall be nominated by the commission after consulting with the statewide association of hospitals. The person representing nursing shall be nominated by the commission after consultation with the statewide association of nursing. No physician member of the panel shall practice in the same medical specialty as any other physician member nor conduct his or her primary practice in the same county, as any other

physician member. At least two members of the panel shall have experience in the administration of utilization review systems.

2484.5. Members of the panel shall serve for a term of four years, except that members first appointed shall serve for staggered terms, as designated by the Governor. A member whose term has expired shall continue to serve until his or her successor is appointed and qualified. Appointments to fill vacancies shall be for the unexpired term. Members of the panel shall receive one hundred dollars ($100) for each day while on official business of the panel. In addition, each member shall be entitled to receive actual expenses incurred in the discharge of his or her duties, including actual and necessary travel expenses.

2485. The Medical Policy Panel shall have the authority to do all of the following:

(a) Recommend to the commission those health care procedures, services, drugs or devices that are experimental, investigational, outmoded, not efficacious, or otherwise not sufficiently cost-effective to be included in basic health care coverage. In making these determinations, the panel shall consider the opinions of the state and national medical and specialty organizations, the National Institutes of Health, the Agency for Health Care Policy and Research, and other interested parties.

(b) Recommend to the commission those indications for prescription drugs that although not approved by the federal Food and Drug Administration, are sufficiently efficacious and cost-effective to be included in basic health care coverage.

(c) Analyze the utilization data collected by the commission for patterns of practice and report annually to the commission its recommendations for improving the quality and availability of care.

(d) Contract with nonprofit professional medical, osteopathic, podiatric, hospital, and health facility societies exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code for peer review to

evaluate aberrant patterns of practice of providers discovered in the course of the panel's duties set forth in subdivision (c) or brought to the attention of the commission by carriers. These contracts shall allow for reimbursement by the commission or the parties seeking the review of the costs of the review, but shall provide no profit to the professional association. Results of the review shall be used solely for peer education of the health care provider or education of the carrier as indicated. If the panel determines that educational efforts have failed, the panel shall refer the matter to the appropriate licensing agency. The records and proceedings of the panel and the contracting organizations shall be confidential unless and until a licensing agency takes formal action.

(e) Review the practice parameters developed by state and national medical and specialty organizations, the National Institutes of Health, and other interested parties and recommend to the commission those practice parameters that may be authorized for use by carriers providing basic health care coverage to deny payment.

(f) Recommend to the commission the scope of basic health care benefits. Any recommendation for a change in the scope of benefits shall include an explanation of the health impact on enrollees.

2485.2. The Medical Policy Panel shall, prior to making any of the recommendations to the commission specified in Section 2485, consider all relevant written comments submitted to it by state and national medical, specialty, and allied health professional organizations.

2485.5. The Medical Policy Panel may establish subcommittees of its members as it deems necessary to assist the panel in the performance of its duties, and may delegate the performance of its peer review duty set forth in subdivision (d) of Section 2485 to any subcommittee that has a minimum of two panel members. The panel may request the assistance of physician and surgeon members of a medical quality review committee established pursuant to Article 13 (commencing with Section 2320) of Chapter 5 of Division

2 of the Business and Professions Code, as it deems necessary to assist the panel or its subcommittees in the performance of its duties, and each committee member who agrees to serve shall be subject to applicable laws, rules and regulations as if he or she were a member of the panel.

Article 10. Cost Containment Panel

2486. Upon the nomination of the commission, the Governor shall appoint a Cost Containment Panel that shall be composed of one person representing businesses with 50 or more employees, one person representing businesses with fewer than 50 employees, one person representing employee organizations, one person representing hospitals, one physician and surgeon licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, or the Osteopathic Act (Initiative Measure, Statutes of 1923, approved by the electors November 7, 1922; see Chapter 8 (commencing with Section 3600) of Division 2 of the Business and Professions Code), one person representing registered nurses, one person representing a health care service plan regulated under the Knox-Keene Health Care Services Plan Act (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), one person representing disability insurers providing coverage of hospital, medical and surgical expenses, and one person representing consumers at large. The physician panel member shall be in the active practice of medicine and shall be nominated by the commission after consultation with the statewide association of the medical profession. The person representing hospitals shall be nominated by the commission after consulting with the statewide association of hospitals. The person representing nursing shall be nominated by the commission after consultation with the statewide association of nursing.

2486.5. Members of the Cost Containment Panel shall serve for a term of four years, except that members first

appointed shall serve for staggered terms, as designated by the Governor. A member whose term has expired shall continue to serve until his or her successor is appointed and qualified. Appointments to fill vacancies shall be for the unexpired term. Members of the panel shall receive one hundred dollars ($100) for each day while on official business of the panel. In addition, each member shall be entitled to receive actual expenses incurred in the discharge of his or her duties, including actual and necessary travel expenses.

2487. The Cost Containment Panel shall have the authority to do all of the following:

(a) Act as an appellate body for any beneficiary, physician, other health care provider or carrier who wishes to dispute whether a charge for health care services is excessive. In determining whether a charge is excessive, the panel shall consider the fees charged by other providers in the area for the same procedure, practice costs, and the Harvard Resource Based Relative Value Scale approved by the Physician Payment Review Commission. A panel member who will gain a direct financial benefit from the outcome of the dispute shall not participate in, hear, comment, or advise other members upon, or decide, any appeal under this subdivision.

(b) Analyze the utilization data collected by the commission for patterns of practice and report annually to the commission its recommendations for improving the quality and availability of care.

(c) Report to the commission on the major causes of health care cost escalation, including, but not limited to, the following:

(1) Insurance administration.

(2) Cost shifting by government.

(3) Increased utilization.

(4) Increased technology.

(5) The tort system.

(6) The aging population.

(7) Biological epidemics, including, but not limited to, AIDS, drug abuse, and tobacco use.

(8) Other increases in practice costs.

(d) Recommend to the commission the scope of basic health care benefits. Any recommendations for an increase in benefits shall include an explanation of the projected annual financial effect of the amendment expressed both in the aggregate and the amount of increase in the average premium and cost-sharing expense the average employer and employee would bear.

(e) Recommend to the commission specific cost-containment provisions to be considered by the Legislature.

2487.10. It is the intent of the Legislature to provide guarantees of affordability of the premiums for basic health care coverage if they rise above the limits established pursuant to this chapter.

2487.15. (a) The Cost Containment Panel shall annually set an annual percentage limit for the increase in private health insurance premiums for the basic health care coverage.

(b) The panel shall set the annual limit after considering all of the following:

(1) The capacity of purchasers to pay for coverage including economic conditions and the growth in real wages.

(2) The gross and per capita cost of delivering care, in both managed care and fee-for-service settings, during the prior year.

(3) Changes in health care technology.

(4) The changing demographic composition of the population covered.

(5) Opportunities for more cost-effective and efficient delivery of care.

(6) Changes in cost shifting trends among major public and private payers.

(7) Epidemics and natural disasters that seriously impact health care costs.

(8) Inflation, both in the economy generally and in health care specifically.

(c) The panel shall collect health care expenditures

data in at least the following categories:

(1) Physicians.

(2) Other professional providers.

(3) Hospitals.

(4) Nursing facilities.

(5) Pharmaceuticals.

(6) Insurance premiums.

(d) No carrier shall increase premiums in a percentage amount in excess of the limit set by the panel except as authorized by the panel.

2487.20. The panel shall report annually on the increase in the cost of care and the carriers' premiums for basic health care coverage.

2487.25. (a) For any year following any year in which the total percentage increase in private health insurance premiums for basic health care coverage exceeds the limit established by the panel, the panel shall limit carriers' premiums, hospital rates, and professional fees to maintain the total increase in carrier premiums for basic health care coverage within the limit. The limits shall be for total expenditures but each separate category shall be adjusted so that each category would be protected from cost overruns in any or all other categories.

(b) The panel may, when necessary, set limits on the increase in hospital rates and professional fees in a manner that maintains the total increase for hospital and professional services within the limit, including adjustments for increases in utilization.

2487.30. (a) The panel may, upon determining that it is necessary to maintain the solvency of a carrier, hospital, or other provider, modify the limits established pursuant to this article with regard to a specific carrier, hospital, or other provider.

(b) The panel shall, when making modifications pursuant to subdivision (a), make any adjustments necessary to provide that the total percentage increase in premiums and rates subject to this article do not exceed the total limit.

Article 11. Technology Panel

2488. Upon nomination of the commission, the Governor shall appoint a Technology Panel that shall be composed of one member representing each of the following: carriers, medical researchers, physicians, hospitals, consumers, and business. The physician panel member shall be licensed under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, or the Osteopathic Initiative Act and shall be nominated by the commission after it has consulted with the statewide and local associations of the medical profession. The person representing hospitals shall be nominated by the commission after consulting with the statewide association of hospitals.

2488.5. Members of the Technology Panel shall serve for a term of four years, except that members first appointed shall serve for staggered terms, as designated by the Governor. A member whose term has expired shall continue to serve until his or her successor is appointed and qualified. Appointments to fill vacancies shall be for the unexpired term. Members of the Technology Panel shall receive one hundred dollars ($100) for each day while on official business of the panel. In addition, each member shall be entitled to receive actual expenses incurred in the discharge of his or her duties, including actual and necessary travel expenses.

2489. The Technology Panel shall have authority to do all of the following:

(a) Monitor the development of new health care technology and conduct cost/benefit analyses specific to California's population and health care financing mechanisms while this technology is still in its experimental phases.

(b) Publish recommendations concerning rational dissemination of technology, taking into consideration the beneficial effects of competition.

(c) Publish recommendations concerning the circumstances when new health care technology should be available and target utilization rates that will promote

appropriate use of new technology.

Article 12. Cost Shift Capture

2489.5. (a) Commencing July 1, 1996, general acute care hospitals shall reduce their rates to reflect the elimination of the cost shift for bad debt and charity care to otherwise uninsured individuals who thereafter become insured under this chapter.

(b) The extent of each hospital's rate reduction shall be determined as follows: The amount of bad debt and charity care for the 1994 calendar year as reported by the Office of Statewide Health Planning and Development and adjusted to cost, minus the amount of bad debt and charity care for the 1995 calendar year as reported by the Office of Statewide Health Planning and Development and adjusted to cost, divided by the total revenues from all private carriers, multiplied by individual carrier revenues.

(c) Each private carrier shall reduce its premiums to individual and group purchasers in an amount equal to the dollar decrease in claims expenses due to this section.

(d) No rate or premium reductions are required under this section unless and until there is an actual reduction in bad debt and charity care as reported in the data collected by the Office of Statewide Health Planning and Development.

(e) It is the intent of this section that actual reductions in hospital costs and expenses to care for the uninsured who are covered by this chapter shall be reflected in reduced premium costs to purchasers and payers of hospital services.

(f) The commission shall monitor hospital rates and private carrier premiums to ensure this reduction is reflected in purchaser rates and premiums.

2490. The commission shall determine the percentage of employers in California that voluntarily extend coverage equal to or greater than that provided for in this chapter, and if the commission determines that at least 90 percent of employers have voluntarily

extended this coverage prior to the date the employer would be responsible to provide the coverage, this chapter shall become inoperative with respect to employers, so long as voluntary participation remains at that level.

SEC. 7. Section 3700 of the Labor Code is amended to read:

3700. Every employer except the state shall secure the payment of compensation in one or more of the following ways:

(a) By being insured against liability to pay compensation in one or more insurers duly authorized to write compensation insurance in this state.

(b) By securing from the Director of Industrial Relations a certificate of consent to self-insure, ~~which~~ *that* may be given upon furnishing proof satisfactory to the Director of Industrial Relations of ability to self-insure and to pay any compensation that may become due to his *or her* employees.

(c) For any county, city, city and county, municipal corporation, public district, public agency, or any political subdivision of the state, including each member of a pooling arrangement under a joint exercise of powers agreement (but not the state itself), by securing from the Director of Industrial Relations a certificate of consent to self-insure against workers' compensation claims, which certificate may be given upon furnishing proof satisfactory to the director of ability to administer workers' compensation claims properly, and to pay workers' compensation claims that may become due to its employees. On or before March 31, 1979, a political subdivision of the state ~~which~~ *that*, on December 31, 1978, was uninsured for its liability to pay compensation, shall file a properly completed and executed application for a certificate of consent to self-insure against workers' compensation claims. The certificate shall be issued and be subject to the provisions of Section 3702.

(d) By obtaining a 24-hour health insurance policy that shall provide medical benefits required by this chapter and that shall meet criteria established by the

Department of Insurance by regulation. The 24-hour health insurance policy may provide for health care by a health maintenance organization or a preferred provider organization. The premium for the 24-hour health insurance policy shall be paid entirely by the employer. The 24-hour health insurance policy shall provide all medical treatment coverage required by this division without any payment by the employee of deductibles, copayments, or any share of the premium. In the event an employer obtains a 24-hour health insurance policy to secure payment of compensation as to medical benefits, the employer shall also obtain an insurance policy that shall provide indemnity benefits, so that the total coverage afforded by both the 24-hour health insurance policy and the policy providing indemnity benefits shall provide the total compensation required by this chapter. All of those policies shall meet the requirements for utilization review pursuant to Section 3762.

SEC. 8. Section 3700.2 is added to the Labor Code, to read:

3700.2. Any employer, or association of employers, in complying with this chapter, may arrange to provide health care coverage and the obligation to provide health benefits for workers' compensation coverage in the same contract or policy. Any carrier may provide that consolidated coverage. This section shall not be administered or interpreted to reduce benefits to injured employees.

SEC. 9. Section 3762 is added to the Labor Code, to read:

3762. As a condition of licensure, workers' compensation insurers shall be required to have a utilization review plan that has been approved by the Insurance Commissioner.

For purposes of this section, a utilization review plan shall meet the standards adopted by the Insurance Commissioner pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), which shall include at least the following requirements:

(a) It shall deny reimbursement for any of the following services when they are medically unnecessary :

(1) Diagnostic imaging.
(2) Clinical laboratory.
(3) Radiation oncology.
(4) Home infusion therapy.
(5) Physical therapy.
(6) Physical rehabilitation.
(7) Psychometric testing.
(8) Chiropractic.
(9) Pharmacy.

In the case of ~~any such~~ *this denial, it shall prepare and deliver a detailed explanation setting forth all the facts and circumstances for which the denial was made.*

(b) It shall have available the services of a sufficient number of registered nurses, medical records technicians, or similarly qualified persons supported and supervised by physicians and surgeons licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act to carry out utilization review activities.

(c) It shall have available the services of a sufficient number of physicians and surgeons licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act who are in active practice and who are sufficiently knowledgeable of the standards of care in this state to ensure the adequate review of medical and surgical specialty and subspecialty cases.

(d) It shall utilize only a physician licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act and trained in the relevant specialty or subspecialty to make a final determination that care rendered is medically inappropriate.

(e) It shall protect the confidentiality of medical information in accordance with applicable state and federal laws.

(f) It shall be accessible to patients who are evaluated

or treated under this division and to providers, as defined in subdivision (a) of Section 4609, five working days each week during normal business hours.

(g) It shall meet the following requirements with respect to any concurrent or prior authorization review:

(1) The insurer shall maintain a toll-free telephone number for use by health care providers 24 hours a day, seven days a week. Individuals responding to these phone calls shall be knowledgeable in the program and have authority to either authorize treatment or refer the matter on a timely basis to a physician licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act and trained in the relevant specialty or subspecialty. The insurer shall be prepared to immediately authorize services that, in the judgment of the health care provider, should be performed in less than three working days.

(2) The insurer shall publicize and continue to develop a list of objective medical criteria that indicate when authorization shall be granted. Any request meeting these criteria shall be approved unless contraindicated by specific medical information.

(3) Routine authorization requests shall be processed within three working days. A routine request submitted by a physician and surgeon as defined in Section 3209.3 shall be deemed approved if not denied within three working days.

(4) The insurer shall submit to the Insurance Commissioner every three months its treatment authorization request status report.

SEC. 10. Section 4609 is added to the Labor Code, to read:

4609. (a) It shall be unlawful for any provider who is defined as a physician and surgeon in Section 3209.3 and is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code to charge, bill, or otherwise solicit payment on behalf of, or refer a patient to, a facility for any of the following services, but only to the extent those services are paid pursuant to this

division, if the provider or the provider's immediate family, has an ownership interest in that facility, unless the provider furnishes to the patient a written disclosure as described in subdivision (b):

(1) Diagnostic imaging.

(2) Clinical laboratory.

(3) Radiation oncology.

(4) Home infusion therapy.

(5) Physical therapy.

(6) Physical rehabilitation.

(7) Psychometric testing.

(8) Chiropractic.

(9) Pharmacy.

(b) The disclosure required of providers pursuant to subdivision (a) shall be met if each involved patient receives a written disclosure statement prior to referral for a listed service that includes all of the following:

(1) A statement that the provider or the provider's immediate family possesses an ownership interest in the facility.

(2) A schedule of the approximate charges that the facility intends to charge for the services or procedures to be performed.

(3) The name and address of another facility within the community that provides the same or similar services, unless another facility does not exist within a radius of 20 miles of the facility in which the provider or provider's immediate family member has an ownership interest.

(4) Advice that the patient may choose any available facility for the purpose of obtaining the services or procedures ordered or requested by the provider.

(c) For the purposes of this section, "immediate family" includes the spouse and children of the provider, the parents of the provider and of the provider's spouse, and the spouses of the children of the provider.

(d) The disclosure requirements of subdivisions (a) and (b) shall not apply to any service that is performed within a provider's office. For the purposes of this subdivision, a "provider's office" includes, but is not limited to, (1) an office in which multiple providers share

ancillary services, or (2) the facilities of a group practice.

(e) The disclosure requirements for providers required by subdivisions (a) and (b) shall also apply to general acute care hospitals, as defined in subdivision (a) of Section 1250 of the Health and Safety Code whenever a patient is referred by such a hospital, its employees, or independent contractors for the following services:

(1) A service performed within a general acute care hospital if the unit performing the service is owned or operated by a joint venture.

(2) A service performed in a facility that is not within a general acute care hospital and that is owned or operated in whole or in part by the hospital.

(f) A violation of this section is a public offense, punishable upon conviction by a fine not exceeding ten thousand dollars ($10,000).

(g) A qualified medical evaluator who is found to have committed a violation of this section, in addition to being subject to the penalty prescribed by subdivision (f), may be terminated, suspended, or placed on probation as a qualified medical evaluator by the Industrial Medical Council.

SEC. 11. Section 17053.21 is added to the Revenue and Taxation Code, to read:

17053.21. An eligible employer, as defined in Section 17053.20, providing basic health care coverage pursuant to Chapter 1.5 (commencing with Section 2445) of Part 9 of Division 2 of the Labor Code shall receive the credit allowed by Section 17053.20.

SEC. 12. Section 23615.1 is added to the Revenue and Taxation Code, to read:

23615.1. An eligible employer, as defined in Section 23615, providing basic health care coverage pursuant to Chapter 1.5 (commencing with Section 2445) of Part 9 of Division 2 of the Labor Code shall receive the credit allowed by Section 23615.

SEC. 13. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs which may be incurred by a local agency or school district will be

incurred because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction. Notwithstanding Section 17580 of the Government Code, unless otherwise specified in this act, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

All matter omitted in this version of the bill appears in the bill as amended in the Senate, February 27, 1992 (J.R. 11).

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